

BMJ Open

BMJ Open is committed to open peer review. As part of this commitment we make the peer review history of every article we publish publicly available.

When an article is published we post the peer reviewers' comments and the authors' responses online. We also post the versions of the paper that were used during peer review. These are the versions that the peer review comments apply to.

The versions of the paper that follow are the versions that were submitted during the peer review process. They are not the versions of record or the final published versions. They should not be cited or distributed as the published version of this manuscript.

BMJ Open is an open access journal and the full, final, typeset and author-corrected version of record of the manuscript is available on our site with no access controls, subscription charges or pay-per-view fees (<http://bmjopen.bmj.com>).

If you have any questions on BMJ Open's open peer review process please email editorial.bmjopen@bmj.com

BMJ Open

Communication of disease prognosis and life expectancy in patients with colorectal cancer undergoing palliative care: a qualitative study

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2018-023463
Article Type:	Research
Date Submitted by the Author:	10-Apr-2018
Complete List of Authors:	Rohde, Gudrun; University of Agder, Faculty of Health and Sport Sciences; Sorlandet Hospital , Department of Clinical Research Söderhamn, Ulrika; University of Agder, Centre for Caring Research – Southern Norway, Department of Health and nursing Sciences, Faculty of Health and Sport Sciences Vistad, Ingvild ; Sorlandet Hospital Kristiansand , Obstetric and gynegology
Keywords:	palliative care information, vulnerability, death sentence, life-world, compassion

SCHOLARONE™
Manuscripts

View Only

Communication of disease prognosis and life expectancy in patients with colorectal cancer undergoing palliative care: a qualitative study

Authors:

Gudrun Rohde, PhD (Corresponding author)

Professor, University of Agder, Faculty of Health and Sport Sciences and Department of Clinical Research, Sorlandet Hospital Kristiansand

Postbox 422, 4604 Kristiansand, Norway

Phone: +47 99164094

Email: (gudrun.e.rohde@uia.no)

Ulrika Söderhamn, PhD

Professor

University of Agder, Faculty of Health and Sport Sciences

Postbox 509

4898 Grimstad, Norway

Phone: +47 416 98 753

Email: Ulrika.soderhamn@uia.no

Ingvild Vistad, PhD

Department of Obstetrics and Gynecology, Sorlandet Hospital HF, Kristiansand

Gynaecologist and Professor

Postbox 416, 4604 Kristiansand, Norway

1
2
3 Phone: +47 97532316

4
5 Email: Ingvild.vistad@sshf.no
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21

22 **Abstract:**

23
24 **Objectives** Patients with colorectal cancer receiving non-curative treatment receive extensive
25 amounts of treatment-related information throughout their disease trajectory. We aimed to
26 explore the experiences of patients with incurable colorectal cancer and their reflections upon
27 information given by physicians and nurses while in palliative care. Our main focus was the
28 patients' thoughts about how disease and life expectancy were communicated, from the first
29 time that they were informed about the incurable nature of their disease through to post-
30 surgery palliative treatment.
31
32
33
34
35
36
37
38

39 **Settings** Patients with colorectal cancer receiving non-curative chemotherapy
40

41 **Research design** We used a qualitative approach, and the data were analysed according to
42 qualitative content analysis.
43
44
45

46 **Participants** Twenty patients (34–75 years of age) were included in the study: 12 received
47 first-line chemotherapy, and eight received second-line chemotherapy. Eleven patients were
48 treated by oncologists, and nine were treated by junior physicians.
49
50

51 **Results** Through data-driven empirical analysis, we identified four themes: (1) initial
52 information was perceived as a death sentence, (2) palliative chemotherapy and
53
54
55
56

1
2
3 compassionate physicians and nurses offered hope, (3) the information given should be
4 truthful and (4) professional, personal and organizational factors influenced information and
5 communication.
6
7

8
9 **Conclusion** Receiving the first information of having an incurable disease was experienced as
10 a death sentence, while post-surgery palliative chemotherapy offered hope. The patients
11 preferred customized information about treatment and likely future perspectives, and doctors
12 and nurses with a holistic approach focusing on their life-world with compassion.
13
14

15
16 **Implication for Practice** To be a sensitive, holistic, and compassionate physician or nurse
17 requires knowledge and confidence. To achieve this, training and guidance at universities and
18 in hospital wards are needed.
19
20
21
22
23

24 25 26 **Strengths and limitations of the study**

- 27 • Knowledge of how colorectal cancer in palliative care look upon information and
28 communication of disease and life expectancy throughout the disease trajectory
- 29 • Patients preferences for professional, personal, and especially organizational factors
30 facilitating or inhibiting communication.
- 31 • On group of patients in palliative care
32
33
34
35
36
37
38
39
40
41
42

43 **Key words:** palliative care information; vulnerability; death sentence; life-world, compassion
44

45
46 **Words: 4401**
47
48
49
50
51
52
53
54
55

Background

Patients with cancer treated with non-curative intent receive extensive amounts of disease-related information from the first time that they are informed about the incurable nature of their disease, through the following months or even years with treatment and care¹⁻⁴

Guidelines encourage health care professionals (HCPs) such as physicians and nurses to inform and discuss prognoses and likely future perspectives with the patients. However, many HCPs and patients struggle with the right approach for these discussions.⁵⁻⁷ In a systematic review in 2007, Hancock et al.⁵ showed that although most HCPs believed that patients should be told the truth about their prognosis, in practice, many either avoid discussing the topic or withhold information. Other studies have emphasized that primarily focusing on open communication regarding the bleak prospects of life expectancy entails a risk of overrunning the individual's information needs and hopes.⁸

Most studies focusing on patient–HCP communication of disease and prognosis in patients with incurable cancer are quantitative involving patients in an early stage of the disease.⁶ Qualitative studies show that most patients acknowledge the chronic and incurable nature of their disease^{9 10} and they are aware that that palliative chemotherapy aims to relieve symptoms and, potentially, to postpone death.⁹ Some studies show that many patients prefer a straightforward presentation of their prognosis,^{11 12} while others underline individual differences in the preference for honesty in communication.¹⁰ Some patients even prefer HCPs to avoid being too exact.^{13 14} Patients prefer communication with caring and trusting HCPs.^{11 12 15} Furthermore, patients emphasize personal and professional knowledge of the nurses as being important in palliative care,¹⁶ and their information needs are both disease and illness oriented.¹⁷ Hope is important for patients with incurable cancer, and they appreciate HCPs giving this.^{11 12} There is a fine balance between telling the truth and

1
2
3 nurturing hope,^{13 14} and there is a spectrum of hope, from hope for a cure to hope for living as
4 normally as possible.^{13 14}
5
6

7 Patients with cancer in a palliative phase of treatment are vulnerable, and good
8 patient–HCP relationships are important.¹⁸ The philosopher Løgstrup¹⁹ emphasized the
9 importance of trust in such relationships. Trust is something fundamental in our lives and
10 implies that you expose yourself to others and become vulnerable. Vulnerability implies that
11 others are in control and hold some of their fellow humans' life in their hands.¹⁹ Furthermore,
12 Mishler²⁰ distinguished between the voice of medicine (the technical–scientific assumptions
13 of medicine) and the voice of the life-world (the natural attitudes of everyday life), which
14 represent different ways of conceptualizing and understanding patients' problems in patient–
15 physician communication. He suggested an increased attentiveness to the voice of the patients
16 in terms of their life-world.
17
18
19
20
21
22
23
24
25
26
27

28 Patients with incurable cancer might experience a life crisis when they are informed
29 about the incurable nature of their cancer.²¹ Over time, most of them adjust to their new life
30 situation, and during this time, preferences and experiences regarding information and
31 communication might change.¹⁸ There is limited knowledge of how patients with colorectal
32 cancer in palliative care look upon information and communication of disease and life
33 expectancy throughout the disease trajectory, as there have been few studies with
34 heterogeneous groups of patients. There is also scarce knowledge of professional, personal,
35 and especially organizational factors facilitating or inhibiting communication. Therefore, we
36 aimed to explore the experiences of patients with incurable colorectal cancer and their
37 reflections upon information given by physicians and nurses while in palliative care. Our
38 main focus was the patients' thoughts about how disease prognoses and life expectancy were
39 communicated, from the first time that they were informed about the incurable nature of the
40 disease through to post-surgery treatment.
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55

Methods

We chose a qualitative approach using in-depth interviews^{22 23} and invited patients with metastatic colorectal cancer who were referred for non-curative chemotherapy at three regional hospitals in Southern Norway. Oncologists informed patients at the outpatient clinics about the study when they attended for the second or third cycle of chemotherapy. Surgery is performed at the surgery department, with surgeons being responsible for the patients in this phase. Chemotherapy is provided at an oncological outpatient clinic with oncologists being responsible for the treatment.

The patients were eligible for inclusion if they were aged 18 years or older, had metastatic colorectal cancer, were undergoing surgery for their cancer, had been referred for first- or second-line non-curative chemotherapy, had a life expectancy of >6 months and were able to give written informed consent. We included patients of different ages, marital statuses and other demographic and clinical characteristics.²⁴ We excluded patients with any significant comorbidity that could compromise life expectancy, or inability to understand or read Norwegian. Patients with conditions that the physician believed could affect the patient's ability to understand or cope with the questions were not considered to be eligible, including patients who were considered to be too emotionally vulnerable ($n = 4$). The patients were included consecutively.

Twenty patients with colorectal cancer (34–75 years of age) were invited to participate in the study over a period of 1 year, and all of them accepted the invitation. All patients received combination chemotherapy (see Table 1) and had few physical symptoms related to their disease. The sample comprised 12 patients receiving first-line chemotherapy (five women and seven men) and eight receiving second-line chemotherapy (three women and five men). Eleven patients were treated by oncologists, and nine were treated by junior physicians.

<Table 1 about here>

Data collection

The same researcher (GR) conducted all the interviews. At 2–4 days after the interview, GR contacted the patient and asked whether the interview had influenced him or her negatively. No patients experienced a negative influence or reaction. We performed in-depth interviews lasting 50–100 minutes using a semi-structured interview guide to ensure that we included the issues in focus²² and asked questions such as the following. “What do you think about the first information that you received about your disease?” “How was the information provided about the follow-up chemotherapy and likely future perspectives?” “Have you received the information as you expected or is there anything missing?” After the 11th interview, we did some preliminary analyses and made minor changes to the interview guide to obtain more data on issues that needed to be expanded to answer the research aim; for example, “What characterized the good information that you received versus other information that you were not happy with?” Patients were included until data saturation was achieved.²² One interview took place at the patient’s home. The other interviews took place at the cancer centre or outpatient clinics, at a time when the patients had an appointment. The researchers did not know the patients before the interviews and did not treat the patients.

Analysis

We audiotaped and transcribed the interviews verbatim and made logs after each interview. The data were analysed according to qualitative content analysis to identify the themes in the data. In the discussion, our findings were interpreted in light of the researchers’ previous understanding and theory.²² GR and US are both nurses and professors in health sciences with clinical experience in palliative care. IV is a gynaecologist and professor, also with extensive experience in treating patients with cancer undergoing palliative care.

1
2
3 In the analyses, we (i) read all the interviews to understand the meaning of the whole
4 text, (ii) investigated sentences or sections to expose their meaning and to facilitate the
5 identification of themes, (iii) related sentences or sections to the meaning of the whole text
6 and (iv) identified passages representative of shared understandings between the researchers
7 and participants.²² To support the analysis, we created mind maps and discussed the analysis
8 among the authors. Quotations have been used to illustrate and support the findings. To
9 validate the findings, all authors participated in discussions of the empirical analysis and in
10 writing up the findings.
11
12
13
14
15
16
17
18
19

20 21 **Ethics**

22
23 Voluntariness and confidentiality were assured during the collection, handling and reporting
24 of data.^{25 26} The study was approved by the Regional Committee for Medical Research Ethics
25 (REK South-East 2011/2464).
26
27
28
29

30 31 32 **Patient involvement**

33
34 Before we started the study, we performed three pilot-interviews with cancer patients to test
35 the study design and interview-guide, and we made minor changes to the guide. These
36 interviews are not included in the study. No further patients' involvement was undertaken
37 when it comes to the specific aims or interpretation of the findings. The dissemination of the
38 findings will be this publication.
39
40
41
42
43
44

45 46 **Findings**

47
48 Through data-driven empirical analysis, we identified four themes: (1) initial information was
49 perceived as a death sentence, (2) palliative chemotherapy and compassionate physicians and
50 nurses offered hope, (3) the information given should be truthful and (4) professional,
51 personal and organizational factors influenced information and communication.
52
53
54
55

1
2
3 We did not identify any differences between participants receiving first- or second-line
4
5 chemotherapy.
6
7
8

9 **Initial information was perceived as a death sentence**

10
11 The participants experienced receiving information about the incurable nature of their cancer
12 differently, and the information was given in different settings. Some had to wait a long time
13 (weeks or months) from their first worries about the disease until they could be examined or
14
15 have an appointment at the hospital. When the cancer was finally diagnosed, they received
16
17 limited apologies from the physicians because of the delay and emphasized that an excuse
18
19 would have made the situation easier to handle. Other participants had to wait for weeks
20
21 before they received test results because the results from computer tomography scans had not
22
23 been forwarded quickly enough to the referring doctor. Some had not even felt particularly ill,
24
25 and it was hard for them to understand the message about having an incurable disease when
26
27 the doctor informed them. Most participants were informed about their diagnosis by surgeons,
28
29 except for two who were informed by their general practitioners (GPs). Several participants
30
31 experienced the first information about the incurable nature of their disease as a shock.
32
33
34
35
36

37
38 Some participants reported that surgeons or GPs had given the message in an
39
40 inappropriate way, at an inappropriate place (e.g., in a small examination room). Further
41
42 questions from the participants were answered only to a limited extent, if at all.
43
44

45 *“When the surgeon gave me the message that my disease was incurable, I was shocked, I*
46
47 *didn’t feel that anything was wrong. I asked him how long I had left to live. He just shrugged*
48
49 *and didn’t have any answer. The conversation took 8 minutes.” (patient 4, woman aged 54*
50
51 *years).*
52
53
54
55

1
2
3 The message was experienced as a death sentence, and several participants felt left behind
4 with unanswered questions. The message was brutal to hear; however, some participants
5 admitted that a straightforward message was probably the best way.
6
7

8
9 Some participants experienced that the information before and after the operation was
10 insufficient. A couple of participants received a message that complete tumour resection was
11 impossible or that nearly nothing could be done, and they experienced this as a message of
12
13 “go home and wait for death”.
14
15

16
17
18 *“She (the surgeon) should not talk with people. Or learn a phrase telling the patients that*
19 *other HCPs will talk with you about this.” (patient 4, woman aged 54 years).*
20
21

22
23
24 On the other hand, some of the male participants in particular expressed satisfaction with how
25 the surgeon had given pre- and postoperative information and explained the operation, the
26 consequences and likely future treatment-related effects; e.g., challenges with the stoma or the
27 risk of impotence after the operation.
28
29
30

31 32 33 **Palliative chemotherapy and compassionate physicians and nurses offered hope**

34
35
36 When the participants started their post-surgery chemotherapy at the cancer centre, the
37 palliative treatment was looked upon as a kind of salvation. Further treatment implied hope
38 that something could be done. For many participants, the cancer centre was seen as “heaven”,
39 where physicians and nurses met them with openness, knowledge and enough time. At the
40 cancer centre, nurses and physicians gave hope, and the palliative treatment itself was also
41 perceived as giving hope. The participants emphasized the importance of including hope in
42 patient communication.
43
44
45
46
47
48
49

50
51
52 *“I would like correct information about the situation. But you can give hope at the same time.*
53 *Correct information including hope. Hope is so much.” (patient 17, woman aged 71 years).*
54
55

1
2
3 The participants' hope seemed to change from before they were diagnosed with their
4 incurable disease and through their disease trajectory. Even though they recognized that their
5 cancer was incurable, most hoped that they would be among those who could live for years
6 despite poor a prognosis. As the disease progressed, they hoped for good days, not
7 extraordinary things, or experiences. They just wanted ordinary everyday lives and the
8 possibility of being together with family and friends. The participants wanted to continue to
9 live and to see how things turned out.

10
11
12
13
14
15
16
17
18
19 *"I don't want champagne, caviar and extraordinary things or experiences. Just ordinary*
20 *days."* (patient 3, woman aged 70 years).

21 22 23 24 **The information given should be truthful**

25 Correct and honest information about their disease, treatment effects, side-effects, metastases,
26 and likely future perspectives was important for the participants. They preferred to receive the
27 test results immediately rather than to wait until their next appointment at the cancer centre.
28 Preferences regarding the amount of information that the participants wanted to receive at the
29 time varied. Some participants wanted a total overview of their disease and prognosis from
30 the start, some wanted a smaller amount of information at the time, while others wanted their
31 body to tell them how their disease progressed bit by bit. Most participants found vague
32 information confusing, and in particular some of the male participants wanted straightforward
33 information.

34
35
36
37
38
39
40
41
42
43
44
45
46
47 *"I would like to know even more if it is possible. I don't want them to keep any information*
48 *back. I would like to have a better overview and know what to expect in the future."* (patient
49 *13, man aged 68 years)*

1
2
3 Most participants felt that they had received honest information and answers, and had
4 opportunities to ask questions. Some felt insecure if they were treated by a junior physician
5 who could not answer all their questions.
6
7

8
9
10 *“I would have felt safer if I was treated by a specialist, one who didn’t have to ask colleagues*
11 *to be sure. At least occasionally.” (patient 11, man aged 60 years).*
12
13

14
15 The participants experienced receiving information about their life expectancy at the cancer
16 centre differently. Some found the information to be sufficient and adequate, while other
17 claimed that they had been given very little specific information on this point, if anything at
18 all. Some participants would have liked to know the exact prognosis and time, partly because
19 they wanted to be able to “talk the serious talk” with their closest relatives and to be prepared
20 to die. This was especially important to participants with children or vulnerable relatives. A
21 couple of the participants expressed gratitude that the oncologists had told them their true
22 prognosis even though they did not ask for it.
23
24
25
26
27
28
29
30
31
32
33
34

35 **Professional, personal, and organizational factors influenced information and** 36 **communication** 37

38
39 Most participants wanted their health care and treatment to be organized in such a way that it
40 was possible to see the same physician at each consultation. Some of those who had to
41 alternate between different physicians felt that they had to start from the beginning each time
42 and felt it to be exhausting.
43
44
45
46
47

48
49 *“I am an introverted person. I am not able to speak openly with everyone. When I meet a new*
50 *physician, I have to start from the beginning, and I don’t like it. And it is OK to feel like this.*
51 *We are all different.” (patient 2, woman aged 73 years).*
52
53
54
55

1
2
3 In addition to the discomfiting feeling of having to deal with new physicians, some
4 participants reported that messages had not been forwarded between the different physicians,
5 resulting in mistakes. They felt that no one was in charge of their medical care and felt
6 insecure; for example, when experiencing changes in treatment when they changed
7 physicians/junior doctors. Some of the oldest participants also expressed difficulties in
8 understanding foreign physicians because of language problems. However, they felt
9 comforted that their treatment was discussed in the oncologist collegium. The nurses' and
10 physicians' professional knowledge and ability to answer questions inspired confidence. In
11 addition, the chemotherapy treatment response was important for their confidence, hopes and
12 trust in the treatment that they received.

13
14
15 A combination of professional knowledge and personality was emphasized as
16 important. Furthermore, the participants highly appreciated physicians and nurses with
17 enough time, who knew them and their disease. One participants characterized this as follows.

18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
"She is an oncologist with a heart and a brain." (patient 4, woman 54 years).

61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
841
842
843
844
845
846
847
848
849
850
851
852
853
854
855
856
857
858
859
860
861
862
863
864
865
866
867
868
869
870
871
872
873
874
875
876
877
878
879
880
881
882
883
884
885
886
887
888
889
890
891
892
893
894
895
896
897
898
899
900
901
902
903
904
905
906
907
908
909
910
911
912
913
914
915
916
917
918
919
920
921
922
923
924
925
926
927
928
929
930
931
932
933
934
935
936
937
938
939
940
941
942
943
944
945
946
947
948
949
950
951
952
953
954
955
956
957
958
959
960
961
962
963
964
965
966
967
968
969
970
971
972
973
974
975
976
977
978
979
980
981
982
983
984
985
986
987
988
989
990
991
992
993
994
995
996
997
998
999
1000

The participants preferred nurses and physicians who telephoned to ask how they felt and gave test results or messages if any. At the same time, they appreciated the possibility of contacting the physicians and nurses at the cancer centre if needed, to have "an open door". They wanted physicians and nurses who could see them as a person, not just a patient. The importance of paying attention, making them feel that there was time enough for discussions during the consultations or visits at the cancer centre for chemotherapy, and knowing them without consulting the computer record was emphasized.

1
2
3 *“He saw the person. It was the warmth in his eyes and the way that he sat relaxed in his*
4 *chair. I don’t remember anything from the consultation. I just remember the feeling.” (patient*
5 *18, woman aged 34 years).*
6
7
8
9

10 The participants wanted to see physicians and nurses with a holistic approach to treatment and
11 care, who also wanted to take part in their life-world, not just the physical and mechanical
12 components related to their disease: in other words, they wanted a compassionate physician or
13 nurse. Furthermore, characteristics of the best physicians or nurses were emphasized as
14 knowledge, warmth, and trust. These characteristics were important for how participants felt,
15 for their hopes and for how they handled their disease.
16
17
18
19
20
21
22
23
24
25
26

27 **Discussion**

28
29 Our findings reveal that most participants experienced the first information of their incurable
30 disease as a death sentence. Later on, post-surgery palliative chemotherapy implied hope. The
31 participants preferred truthful information about the treatment and likely future perspectives.
32 They wanted their treatment and care to be organized in a way that they could see the same
33 well-qualified and compassionate physicians each consultation, and the same compassionate
34 nurses when visiting the cancer centre for chemotherapy. To deepen our understanding of the
35 participants’ experiences and reflections, we will discuss the findings in light of previous
36 studies of patient–HCP communications of disease and life expectancy in patients with
37 incurable cancer, applying Løgstrup’s¹⁹ philosophy and Mishler’s²⁰ focus on the patients’
38 voice of their own life-world in patient–physician communication. We will also suggest some
39 implications for HCPs and organizations in terms of cancer treatment and care.
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 The physicians who informed the participants about their incurable cancer might be
4 considered as the bearers of bad news. At that time, the participants were most likely to be in
5 a vulnerable situation, and the relationships between the physician and the participants in
6 these meetings were asymmetrical. The physician held the knowledge and expertise of the
7 disease, and the participants had to trust them.^{8 27} As Løgstrup¹⁹ underlines, this makes them
8 expose themselves to the situation, the message and the follow-up communication.^{28 29}
9
10 According to our participants' experiences, the information and communication in these
11 meetings did not give them sufficient help to handle the message and their vulnerable
12 situation in an appropriate way. They wanted to interact with physicians who were able to
13 give the message in a sensible and sensitive way, and who were able to have more answers
14 and give enough time.³⁰ Additionally, as pointed out in the study by Barnett et al.¹⁸, doctors
15 in surgical specialities are significantly more likely to be rated poorly than non-surgical
16 specialists or GPs when breaking bad news.
17
18
19
20
21
22
23
24
25
26
27
28
29
30

31 The palliative treatment implied hope that something could be done. Previous studies
32 have also underlined how palliative treatments imply hope^{8 31 32} and how important it is to
33 include hope when giving bleak prospects and information about palliative treatment and care.
34
35 ⁸ Hope is an important coping strategy in such patients,^{33 34} and hope has been described as
36 essential in human life, and important for a person's quality of life and well-being.³⁴ Hope is
37 the confident but uncertain expectation of a good future that appears to be realistically
38 possible and is personally significant to the individual.³⁵ The realistic hope for most of our
39 participants was that something could be done to relieve their symptoms and potentially to
40 postpone death, and to enable ordinary everyday lives and the possibility of spending time
41 with family and friends.
42
43
44
45
46
47
48
49
50
51

52 Time and the participants' previous experience and life situation might have
53 influenced how they experienced the information at the cancer centre, how much they were
54
55

1
2
3 prepared to “fight” and which coping strategies they used. According to Lazarus and Folkman
4
5 ²⁹ coping is a positive response to stress (such as incurable cancer disease) related to the
6
7 person’s cognitive and behavioural efforts to handle the stress. The process of coping includes
8
9 two main orientations: problem-focused and emotion-focused coping. The participants used
10
11 both problem-focused and emotionally focused coping strategies to handle the information
12
13 and communication. ³⁰ However, some participants seemed to struggle with the balance
14
15 between these approaches using mostly an emotional coping strategy to handle troublesome
16
17 thoughts and worries related to their disease and situation which most likely can be
18
19 characterized as a part of a normal way to handle such a stressful situation. ³⁶
20
21

22 Previous studies indicate that patients with incurable cancer want truthful information
23
24 about their disease, treatment, and likely future perspectives. ^{37 38} However, there are
25
26 individual preferences, and individual customized approaches seem to be necessary. ^{39 40} In
27
28 the present study this is illustrated by the diversity of how detailed information the
29
30 participants wanted about their disease and likely future perspectives. The individual variety
31
32 and preferences of the participants might be considered as an important part of their life-
33
34 world, which should be attended to in communication between patients and physicians or
35
36 nurses. ¹⁹ Additionally, coping orientation (problem-focused or emotion-focused), ³⁰ along
37
38 with previous experiences, personality traits and perhaps robustness, might have influenced
39
40 how they experienced and preferred the information and communication.
41
42
43

44 An organization of palliative treatment and care with the same well-qualified
45
46 physician or nurse each time they visited the cancer centre was emphasized as being
47
48 important for the participants to be able to feel safe and to increase the possibility of
49
50 individual and customized care, and to be able to open up their inner thoughts. The
51
52 participants seemed to prefer physician or nurse communications to include what Mishler ²⁹
53
54 has characterized as the “voice of medicine”, which mainly focuses on the symptoms and
55
56

1
2
3 medical and technical problems or aspects of the disease, and they also wanted physicians and
4
5 nurses to initiate communication focusing on the participants' inner thoughts related to their
6
7 illness—what Mishler²⁹ calls the “voice of lifeworld”— including more open-ended
8
9 questions. Such physicians and nurses might be characterized as compassionate caregivers.
10
11 Compassion requires resilience, fortitude and sometimes risk-taking, but always tenacity and
12
13 determination.⁴¹
14
15

16 **Implications for health care**

17
18 It might be considered to be overly demanding and tough to be the bearer of bad news of an
19
20 incurable disease. Some of our participants even pointed out that surgeons who are unable to
21
22 give the message in an appropriate way should not communicate with patients. Rogg et al.⁸
23
24 showed in their study that the Norwegian guidelines and training for physicians
25
26 communication of bleak prognosis were not sufficient. Further, they found that most
27
28 physicians reported that their education for such communication was achieved mainly through
29
30 observing colleagues and training.⁸ Our findings also emphasize that training and guidance of
31
32 communication should be organized better not only during university studies but also in
33
34 hospital wards.
35
36
37

38
39 Physicians and nurses have extensive responsibilities in how they communicate with
40
41 patients with incurable disease. The relationship between patients and HCPs is asymmetrical.
42
43 The HCPs have knowledge of how the disease will most likely progress, and also common
44
45 psychological responses. However, the patients' inner thoughts and life-world are not
46
47 necessarily known to the HCP. The responsibility to initiate or invite communication on
48
49 patients' inner thoughts and to start communication focusing on these issues is in the hands of
50
51 physicians and nurses. Furthermore, it is important to strive for a more symmetrical
52
53
54
55
56
57
58
59
60

1
2
3 relationship between patients and HPCs,^{19 28} which will also increase the possibility of shared
4
5 decision-making in treatment and care.
6

7 Throughout their disease trajectory, the participants in our study preferred
8
9 individualized and customized information and communication. Physicians and nurses have to
10
11 be aware of, and to focus on, this whenever they inform and communicate with patients about
12
13 their disease and life expectancy. This requires not only communication skills but also enough
14
15 knowledge of the medical and psychological issues related to the disease and how these might
16
17 progress.
18

19
20 The participants preferred compassionate physicians and nurses. Being compassionate
21
22 requires more than empathy; it requires knowledge, proactivity and interconnectedness.⁴¹
23
24 Furthermore, to become a compassionate physician or nurse, training is required through
25
26 observation, guidance and feedback on one's own practice.⁴¹ HCPs also need to be aware of
27
28 how much information each patient prefers, and this awareness is associated with years of
29
30 practice and confidence. In addition, the treatment and care of patients undergoing palliative
31
32 chemotherapy should be organized in such a way that patients are able to see the same well-
33
34 qualified physicians and optionally also the same nurses at each consultation or visit at the
35
36 cancer centre.
37
38

39 40 **Methodological considerations**

41
42 The strengths of the study are that the 20 participants provided us with rich data about their
43
44 experiences, feelings and reflections upon HCPs' information and communication of disease
45
46 and life expectancy during their disease trajectory. The authors are two nurses and a
47
48 gynaecologist treating patients with cancer, all with clinical experience and knowledge in
49
50 treating and caring for several patient groups within palliative care, which were used in the
51
52 discussion of the findings. Qualitative content analysis aims to stay close to the data and texts
53
54
55

1
2
3 to reveal the findings; however, the researchers' pre-understanding might also have
4
5 influenced the analysis of the data.
6

7 We studied patients with one type of cancer who were in the palliative phase, which
8
9 can have both positive and negative implications. Variations in socio-demographic factors
10
11 such as gender, age, and marital status, were in accordance of patients with colorectal cancer
12
13 as reported in Jemal A et al.²¹ On the other hand, studying just one patient group might also
14
15 limit the variance in findings that more heterogeneous groups might have brought. Although
16
17 our findings might not be generalizable to patients with other cancer diagnoses, the findings
18
19 can be transferable to hospitals with similar organisation of surgery and post-surgery
20
21 palliative treatments.
22
23

24 25 **Conclusions**

26
27 These findings provide a deeper knowledge of how patients with incurable colorectal cancer
28
29 in the palliative phase experience and reflect upon HCP–patient communications on disease
30
31 and life expectancy from before the surgery through to post-surgery chemotherapy. While the
32
33 first receipt of information of having an incurable disease was experienced as a death
34
35 sentence, post-surgery palliative chemotherapy offered some hope. The participants preferred
36
37 individualized information about the treatment and likely future perspectives, and HCPs with
38
39 individualized information about the treatment and likely future perspectives, and HCPs with
40
41 a holistic approach, including an ability to focus on their life-world with compassion.
42
43
44
45
46

47 **Authors 'contributions**

48
49
50 GR and IV were responsible for the study design

51
52
53 GR was responsible for the patient interviews and data collection
54
55

1
2
3 GR, US and IV contributed to a critical appraisal of the analyses, manuscript preparation and
4
5 have read and approved the final version of the manuscript.
6
7
8
9

10 **Competing interests:** The authors declare that they have no competing interests.
11
12
13
14
15

16 **Acknowledgement:** We thank the Department of Clinical Research at Sorlandet Hospital and
17
18 the Faculty of Health and Sport Science, University of Agder for funding the study.
19

20 Gudrun Rohde was a visiting researcher, as an Affiliate Academic, in the Marie Curie
21
22 Palliative Care Research Department, University College London, January-June 2017 while
23
24 writing most of the paper. We wish to thank the three patients who helped us in designing the
25
26 study. We also want to thank all the patients who participated.
27
28
29

30 **References**

- 31
32 1. McRee AJ, Goldberg RM. Optimal management of metastatic colorectal cancer: current
33 status. *Drugs* 2011;71(7):869-84.
- 34 2. Cameron J, Waterworth S. Patients' experiences of ongoing palliative chemotherapy for
35 metastatic colorectal cancer: a qualitative study. *International journal of palliative*
36 *nursing* 2014;20(5):218-24. [published Online First: 2014/05/24]
- 37 3. Cameron MG, Kersten C, Guren MG, et al. Palliative pelvic radiotherapy of symptomatic
38 incurable prostate cancer - a systematic review. *Radiother Oncol* 2014;110(1):55-60.
39 doi: 10.1016/j.radonc.2013.08.008 [published Online First: 2013/09/21]
- 40 4. Cameron MG, Kersten C, Vistad I, et al. Palliative pelvic radiotherapy for symptomatic
41 rectal cancer - a prospective multicenter study. *Acta Oncol* 2016;55(12):1400-07. doi:
42 10.1080/0284186x.2016.1191666 [published Online First: 2016/06/23]
- 43 5. Hancock K, Clayton JM, Parker SM, et al. Truth-telling in discussing prognosis in
44 advanced life-limiting illnesses: a systematic review. *Palliat Med* 2007;21(6):507-17.
45 doi: 10.1177/0269216307080823 [published Online First: 2007/09/12]
- 46 6. Hagerty RG, Butow PN, Ellis PM, et al. Communicating prognosis in cancer care: a
47 systematic review of the literature. *Ann Oncol* 2005;16(7):1005-53. doi:
48 10.1093/annonc/mdj211 [published Online First: 2005/06/09]
- 49 7. Chou WS, Hamel LM, Thai CL, et al. Discussing prognosis and treatment goals with
50 patients with advanced cancer: A qualitative analysis of oncologists' language. *Health*
51 *expectations : an international journal of public participation in health care and*
52
53
54
55

- 1
2
3 *health policy* 2017;20(5):1073-80. doi: 10.1111/hex.12549 [published Online First:
4 2017/03/07]
- 5 8. Rogg L, Aasland OG, Graugaard PK, et al. Direct communication, the unquestionable
6 ideal? Oncologists' accounts of communication of bleak prognoses. *Psychooncology*
7 2010;19(11):1221-28.
- 8 9. Martinsson L, Axelsson B, Melin-Johansson C. Patients' perception of information from
9 physicians during palliative chemotherapy: a qualitative study. *Psychooncology*
10 2016;14(5):495-502. doi: 10.1017/S1478951515001200
- 11 10. Murray CD, McDonald C, Atkin H. The communication experiences of patients with
12 palliative care needs: A systematic review and meta-synthesis of qualitative findings.
13 *Palliative & supportive care* 2015;13(2):369-83. doi: 10.1017/s1478951514000455
14 [published Online First: 2014/05/03]
- 15 11. Butow PN, Dowsett S, Hagerty R, et al. Communicating prognosis to patients with
16 metastatic disease: what do they really want to know? *Support Care Cancer*
17 2002;10(2):161-8. doi: 10.1007/s005200100290 [published Online First: 2002/02/28]
- 18 12. Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and
19 their families want to be told? A Canadian and Australian qualitative study. *BMJ*
20 2004;328(7452):1343. doi: 10.1136/bmj.38103.423576.55 [published Online First:
21 2004/05/21]
- 22 13. Clayton JM, Butow PN, Arnold RM, et al. Fostering coping and nurturing hope when
23 discussing the future with terminally ill cancer patients and their caregivers. *Cancer*
24 2005;103(9):1965-75. doi: 10.1002/cncr.21011 [published Online First: 2005/03/25]
- 25 14. Clayton JM, Butow PN, Arnold RM, et al. Discussing life expectancy with terminally ill
26 cancer patients and their carers: a qualitative study. *Support Care Cancer*
27 2005;13(9):733-42. doi: 10.1007/s00520-005-0789-4 [published Online First:
28 2005/03/12]
- 29 15. Stajduhar KI, Thorne SE, McGuinness L, et al. Patient perceptions of helpful
30 communication in the context of advanced cancer. *J Clin Nurs* 2010;19(13-14):2039-
31 47. doi: 10.1111/j.1365-2702.2009.03158.x [published Online First: 2010/10/06]
- 32 16. Richardson J. Health promotion in palliative care: the patients' perception of therapeutic
33 interaction with the palliative nurse in the primary care setting. *J Adv Nurs*
34 2002;40(4):432-40. [published Online First: 2002/11/08]
- 35 17. Kutner JS, Steiner JF, Corbett KK, et al. Information needs in terminal illness. *Soc Sci*
36 *Med* 1999;48(10):1341-52. [published Online First: 1999/06/16]
- 37 18. Barnett MM. Effect of breaking bad news on patients' perceptions of doctors. *Journal of*
38 *the Royal Society of Medicine* 2002;95(7):343-7. [published Online First: 2002/07/02]
- 39 19. Løgstrup KE. The ethical demand. Notre Dame, Ill: University of Notre Dame Press 1997.
- 40 20. Mishler EG. The Discourse of Medicine - Dialectics of Medical Interviews 1984.
- 41 21. Jemal A, Center MM, DeSantis C, et al. Global patterns of cancer incidence and mortality
42 rates and trends. *Cancer Epidemiol Biomarkers Prev* 2010;19(8):1893-907. doi:
43 10.1158/1055-9965.epi-10-0437 [published Online First: 2010/07/22]
- 44 22. Crabtree BF, Miller WL. Doing qualitative research. Thousand Oaks, Calif.: Sage 1999.
- 45 23. Earle V. Phenomenology as research method or substantive metaphysics? An overview of
46 phenomenology's uses in nursing. *NursPhilos* 2010;11(4):286-96.
- 47 24. Polit DF. Essentials of nursing research: methods, appraisal, and utilization. Philadelphia:
48 Lippincott Williams & Wilkins 2006.
- 49 25. Beauchamp TL, Childress JF. Principles of biomedical ethics. 7th ed. ed. New York:
50 Oxford University Press 2013.

26. WMA Declaration of Helsinki. Ethical Principles for Medical Research Involving Human Subjects 2013 [Available from: <http://www.wma.net/en/30publications/10policies/b3/>.
27. Rogg L, Loge JH, Aasland OG, et al. Physicians' attitudes towards disclosure of prognostic information: a survey among a representative cross-section of 1605 Norwegian physicians. *Patient Educ Couns* 2009;77(2):242-7. doi: 10.1016/j.pec.2009.03.007 [published Online First: 2009/04/10]
28. Friedrichsen MJ, Strang PM, Carlsson ME. Breaking bad news in the transition from curative to palliative cancer care--patient's view of the doctor giving the information. *Support Care Cancer* 2000;8(6):472-8. [published Online First: 2000/11/30]
29. G ME. *The Discourse of Medicine - Dialectics of Medical Interviews*. New Jersey: Ablex Publishing Corporation, Norwood, New Jersey 1984.
30. Lazarus RS, Folkman S. *Stress, appraisal, and coping*. New York: Springer 1984.
31. Parker SM, Clayton JM, Hancock K, et al. A systematic review of prognostic/end-of-life communication with adults in the advanced stages of a life-limiting illness: patient/caregiver preferences for the content, style, and timing of information. *J Pain Symptom Manage* 2007;34(1):81-93. doi: 10.1016/j.jpainsymman.2006.09.035 [published Online First: 2007/05/29]
32. Benzein E, Norberg A, Saveman BI. The meaning of the lived experience of hope in patients with cancer in palliative home care. *Palliat Med* 2001;15(2):117-26. [published Online First: 2001/04/17]
33. Hegarty M. The Dynamic of Hope: Hoping in the Face of Death. *Progress in Palliative Care* 2001;9(2):42-46. doi: 10.1080/09699260.2001.11746903
34. Rustoen T. Hope and quality of life, two central issues for cancer patients: a theoretical analysis. *Cancer Nurs* 1995;18(5):355-61. [published Online First: 1995/10/01]
35. Dufault K, Martocchio BC. Symposium on compassionate care and the dying experience. Hope: its spheres and dimensions. *Nurs Clin North Am* 1985;20(2):379-91. [published Online First: 1985/06/01]
36. Folkman S. Positive psychological states and coping with severe stress. *Soc Sci Med* 1997;45(8):1207-21. doi: 10.1016/S0277-9536(97)00040-3
37. Miccinesi G, Bianchi E, Brunelli C, et al. End-of-life preferences in advanced cancer patients willing to discuss issues surrounding their terminal condition. *Eur J Cancer Care (Engl)* 2012;21(5):623-33. doi: 10.1111/j.1365-2354.2012.01347.x [published Online First: 2012/04/24]
38. Hagerty RG, Butow PN, Ellis PA, et al. Cancer patient preferences for communication of prognosis in the metastatic setting. *J Clin Oncol* 2004;22(9):1721-30. doi: 10.1200/jco.2004.04.095 [published Online First: 2004/05/01]
39. Mackenzie LJ, Carey ML, Paul CL, et al. Do we get it right? Radiation oncology outpatients' perceptions of the patient centredness of life expectancy disclosure. *Psychooncology* 2013;22(12):2720-8. doi: 10.1002/pon.3337 [published Online First: 2013/06/27]
40. Walczak A, Butow PN, Davidson PM, et al. Patient perspectives regarding communication about prognosis and end-of-life issues: how can it be optimised? *Patient Educ Couns* 2013;90(3):307-14. doi: 10.1016/j.pec.2011.08.009 [published Online First: 2011/09/17]
41. Larkin PJ. *Compassion - The Essence of Palliative and End-of-life Care*. First ed. New York: Oxford University Press 2016.

Table 1: Characteristics of patients receiving non-curative chemotherapy.

	First-line (<i>n</i> = 12)	Second-line (<i>n</i> = 8)
Women	5	3
Men	7	5
Mean age (range), years	63 (34–75)	69 (64–75)
Marital status:		
Married/cohabiting	10	8
Single	1	
Widow/widower	1	
Chemotherapy used:		
Fliri/bevacizumab	10	
Flox (5-fluorouracil, folinic acid, axaliplatin)	1	8
Capecitabine plus oxaliplatin (Xelox)	1	

All patients received 5-fluorouracil-based combination chemotherapy with irinotecan or oxaliplatin, +/- bevacizumab.

Table 1

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	G Rohde (All interviews), p 7
2.	Credentials	PhD and professors, p 1
3.	Occupation	Professors, p 1
4.	Gender	All female, p 7
5.	Experience and training	All were trained researchers, p 7
Relationship with participants		
6.	Relationship established	No relationship before the interviews, p 7
7.	Participant knowledge of the interviewer	The participants did not know the interviewer, p 7
8.	Interviewer characteristics	Nurse and professor and had interests for the topic, p 7
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	Content analysis, p7
Participant selection		
10.	Sampling	The patients physicians asked if the researcher could contact them for inclusion, p 6
11.	Method of approach	Face-to-face, p 7
12.	Sample size	Twenty patients (Twelve men and eight women), p 6

No	Item	Guide questions/description
13.	Non-participation	We have limited information about this, p 6
Setting		
14.	Setting of data collection	Out-patient clinic and patients home (one patient), p 7
15.	Presence of non-participants	Non, p 6
16.	Description of sample	Patients with metastatic colorectal cancer receiving non-curative chemotherapy, p 6
Data collection		
17.	Interview guide	The interview guide was made by the researchers, p 7 and 8
18.	Repeat interviews	No repeated interviews were performed, p 7
19.	Audio/visual recording	Audio recording was used to collect the data, p 7
20.	Field notes	Field notes were made after the interviews, not stated in the manuscript
21.	Duration	50-100 minutes, p 7
22.	Data saturation	Data saturation was discussed and reached, p 7
23.	Transcripts returned	The transcripts were not returned to participants for comments, not stated in the manuscript
Domain 3: analysis and findingsz		
Data analysis		
24.	Number of data coders	one, p 8
25.	Description of the coding tree	The authors provided a description of the coding, p 8
26.	Derivation of themes	The themes were derived from the data, p 8

No	Item	Guide questions/description
27.	Software	none
28.	Participant checking	The participants did not provide feedback on the findings, not written in the manuscript
Reporting		
29.	Quotations presented	The quotations presented illustrate the themes / findings, p 9 - 14
30.	Data and findings consistent	There was consistency between the data presented and the findings p 8 - 14
31.	Clarity of major themes	Major themes were clearly presented in the findings, p 8
32.	Clarity of minor themes	No

BMJ Open

Communication of disease prognosis and life expectancy in patients with colorectal cancer undergoing palliative care: a qualitative study

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2018-023463.R1
Article Type:	Research
Date Submitted by the Author:	13-Jul-2018
Complete List of Authors:	Rohde, Gudrun; University of Agder, Faculty of Health and Sport Sciences; Sorlandet Hospital , Department of Clinical Research Söderhamn, Ulrika; University of Agder, Centre for Caring Research – Southern Norway, Department of Health and nursing Sciences, Faculty of Health and Sport Sciences Vistad, Ingvild ; Sorlandet Hospital Kristiansand , Obstetric and gynecology
Primary Subject Heading:	Palliative care
Secondary Subject Heading:	Communication
Keywords:	palliative care information, vulnerability, life-world, compassion

SCHOLARONE™
Manuscripts

Communication of disease prognosis and life expectancy in patients with colorectal cancer undergoing palliative care: a qualitative study

Authors:

Gudrun Rohde, PhD (Corresponding author)

Professor, University of Agder, Faculty of Health and Sport Sciences and Department of Clinical Research, Sorlandet Hospital Kristiansand

Postbox 422, 4604 Kristiansand, Norway

Phone: +47 99164094

Email: (gudrun.e.rohde@uia.no)

Ulrika Söderhamn, PhD

Professor

University of Agder, Faculty of Health and Sport Sciences

Postbox 509

4898 Grimstad, Norway

Phone: +47 416 98 753

Email: Ulrika.soderhamn@uia.no

Ingvild Vistad, MD PhD

Department of Obstetrics and Gynecology, Sorlandet Hospital HF, Kristiansand

Gynaecologist and Professor

Postbox 416, 4604 Kristiansand, Norway

1
2
3 Phone: +47 97532316
4

5 Email: Ingvild.vistad@sshf.no
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For peer review only

Abstract:

Objectives Patients with colorectal cancer undergoing palliative treatment receive extensive amounts of treatment-related information throughout their disease trajectory. We aimed to explore the experiences of patients with incurable colorectal cancer and their reflections upon information given by physicians and nurses while in palliative care. Our main focus was the patients' thoughts about how disease information and life expectancy were communicated, from the first time that they were informed about the incurable nature of their disease through to post-surgery palliative treatment.

Settings Patients with colorectal cancer receiving palliative chemotherapy.

Research design We used a qualitative approach, and the data were analysed according to qualitative content analysis.

Participants Twenty patients (34–75 years of age) were included in the study: 12 received first-line chemotherapy, and eight received second-line chemotherapy. Eleven patients were treated by oncologists, and nine were treated by junior physicians.

Results Through data-driven empirical analysis, we identified four themes: (1) insufficient initial information, (2) palliative chemotherapy and compassionate physicians and nurses offered hope, (3) the information given should be truthful and (4) professional, personal and organizational factors influenced information and communication.

Conclusion Receiving the first information of having an incurable disease was experienced as insufficient, while post-surgery palliative chemotherapy offered hope. The patients preferred customized information about treatment and likely future perspectives, and doctors and nurses with a holistic approach focusing on their life-world with compassion.

Implication for Practice To be a sensitive, holistic, and compassionate physician or nurse requires knowledge and confidence. To achieve this, training and guidance at universities and in hospitals are needed.

Strengths and limitations of the study

- A strength is that the study shows palliative colorectal cancer patients' thoughts about how disease information, prognoses and life expectancy were communicated, from the first time that they were informed about the incurable nature of the disease *through* to post-surgery treatment.
- The study highlights palliative colorectal patients' preferences for professional, personal, and organizational factors facilitating or inhibiting communication.
- It can be seen as a limitation to focus on one group of patients in palliative care, because it can limit the variance in findings that more heterogeneous groups might have brought.
- The patients were interviewed during chemotherapy at one time point only and their memory about first information may have been coloured by later experiences.

Key words: palliative care information; vulnerability; life-world, compassion

Words: 4401

Background

Patients with cancer treated with palliative intent receive extensive amounts of disease-related information from the first time they are informed about the incurable nature of their disease, through the following months or even years with treatment and care.¹⁻⁴ Guidelines encourage health care professionals (HCPs) such as physicians and nurses to inform and discuss prognoses and likely future perspectives with the patients. However, many HCPs and patients struggle with the right approach for these discussions.⁵⁻⁷ In a systematic review in 2007, Hancock et al.⁵ showed that although most HCPs believed that patients should be told the truth about their prognosis, in practice, many either avoid discussing the topic or withhold information. Other studies have emphasized that primarily focusing on open communication regarding the bleak prospects of life expectancy entails a risk of overrunning the individual's information needs and hopes.⁸ Further, Chen et al.⁹ showed that about half of cancer patients with advanced disease accurately understood their prognosis. In-depth studies on patients' experiences about information given by physicians throughout the disease trajectory are needed in order to guide HCP how to communicate palliative patients' diagnosis and life-expectancy.

Most studies focusing on patient–HCP communication of disease and prognosis in patients with incurable cancer are quantitative involving patients in an early stage of the disease.⁶ Qualitative studies show diverging results regarding the patient's acceptance of the chronic and incurable nature of their disease, and the presentation of their prognosis¹⁰⁻¹⁶. Patients prefer communication with caring and trusting HCPs.^{12 13 16} Furthermore, patients emphasize personal and professional knowledge of the nurses as being important in palliative care,¹⁷ and their information needs are both disease and illness oriented.

Patients with cancer in a palliative phase of treatment are vulnerable, and good patient–HCP relationships are important.¹⁸ The philosopher Løgstrup¹⁹ emphasized the

1
2
3 importance of trust in such relationships. Trust is something fundamental in our lives and
4 implies that you expose yourself to others and become vulnerable. Vulnerability implies that
5 others are in control and hold some of their fellow humans' life in their hands.¹⁹ Furthermore,
6
7 Mishler²⁰ distinguished between the voice of medicine (the technical–scientific assumptions
8 of medicine) and the voice of the life-world (the natural attitudes of everyday life), which
9 represent different ways of conceptualizing and understanding patients' problems in patient–
10 physician communication. He suggested an increased attentiveness to the voice of the patients
11 in terms of their life-world, especially in vulnerable patients like patients in palliative care.
12
13
14
15
16
17
18
19

20 Patients with incurable cancer often experience a life crisis when they are informed
21 about the incurable nature of their cancer.²¹ Over time, the majority adjust to their new life
22 situation, and during this time, preferences and experiences regarding information and
23 communication might change.¹⁸ Colorectal cancer patients represent one of the most common
24 cancer types^{21 22} and there is limited knowledge of how this patient group look upon
25 information and communication of disease and life expectancy *throughout* the disease
26 trajectory, as most studies include heterogeneous groups of patients. There is also scarce
27 knowledge of professional, personal, and especially organizational factors facilitating or
28 inhibiting communication. Therefore, we aimed to explore the experiences of patients with
29 incurable colorectal cancer and their reflections upon information given by physicians and
30 nurses while in palliative care. Our main focus was the patients' thoughts about how disease
31 information, prognoses and life expectancy were communicated, from the first time that they
32 were informed about the incurable nature of the disease through to post-surgery palliative
33 treatment.
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Methods

We chose a qualitative inductive approach using in-depth interviews.²³ As a part of a larger study²⁴ we invited patients with metastatic colorectal cancer who were referred for palliative chemotherapy at three regional hospitals in Southern Norway. Oncologists informed patients at the outpatient clinics about the study when they attended for the second or third cycle of chemotherapy. Surgery is performed at the surgery department, with surgeons being responsible for the patients in this phase. Chemotherapy is provided at an oncological outpatient clinic with oncologists being responsible for the treatment.

The patients were eligible for inclusion if they were aged 18 years or older, had metastatic colorectal cancer, were undergoing surgery for their cancer, had been referred for first- or second-line palliative chemotherapy, had a life expectancy of >6 months and were able to give written informed consent. We included patients of different ages, marital statuses and other demographic and clinical characteristics.²⁵ We excluded patients with any significant comorbidity that could compromise life expectancy, or inability to understand or read Norwegian. Patients with conditions that the physician believed could affect the patient's ability to understand or cope with the questions were not considered to be eligible, including patients who were considered to be too emotionally vulnerable ($n = 4$). The patients were included consecutively.

Twenty patients with colorectal cancer (34–75 years of age) were invited to participate in the study over a period of 1 year, and all of them accepted the invitation. All patients received combination chemotherapy (see Table 1) and had few physical symptoms related to their disease. The sample comprised 12 patients receiving first-line chemotherapy (five women and seven men) and eight receiving second-line chemotherapy (three women and five men). Eleven patients were treated by oncologists, and nine were treated by junior physicians.

<Table 1 about here>

Data collection

The same researcher (GR) conducted all the interviews. At 2–4 days after the interview, GR contacted the patient and asked whether the interview had influenced him or her negatively. No patients experienced a negative influence or reaction. We performed in-depth interviews lasting 50–100 minutes using a semi-structured interview guide to ensure that we included the issues in focus²³ and asked questions such as the following. “What do you think about the first information that you received about your disease and the prognosis?” “How was the information provided about the follow-up chemotherapy and likely future perspectives?” “Have you received the information as you expected or is there anything missing?” “What are important when giving disease information and prognosis, and how do you want it to be given/delivered?” After the 11th interview, we did some preliminary analyses and made minor changes to the interview guide to obtain more data on issues that needed to be expanded to answer the research aim; for example, “What characterized the good information that you received versus other information that you were not happy with?” Patients were included until data saturation was achieved, indicated by minor new information in interview 19 and 20.²³ One interview took place at the patient’s home. The other interviews took place at the cancer centre or outpatient clinics, at a time when the patients had an appointment. The researchers did not know the patients before the interviews and did not treat the patients.

Analysis

We audiotaped and transcribed the interviews verbatim and made logs after each interview. The data were analysed according to qualitative content analysis to identify the themes in the data. In the discussion, our findings were interpreted in light of the researchers’ previous understanding and theory. GR and US are both nurses and professors in health sciences with

1
2
3 clinical experience in palliative care. IV is a gynaecologist and professor, also with extensive
4
5 experience in treating patients with cancer undergoing palliative care.
6

7 In the analyses, we (i) read all the interviews to understand the meaning of the whole
8
9 text, (ii) investigated sentences or sections to expose their meaning and to facilitate the
10
11 identification of themes, (iii) related sentences or sections to the meaning of the whole text
12
13 and (iv) identified passages representative of shared understandings between the researchers
14
15 and participants. To support the analysis, we created mind maps and discussed the analysis
16
17 among the authors. The analysis steps were followed carefully, which increases the reliability
18
19 of the study. Quotations have been used to illustrate and support the findings, and by that
20
21 increasing the trustworthiness. To validate the findings, all authors participated in discussions
22
23 of the empirical analysis and in writing up the findings.
24
25

26 27 **Ethics**

28
29
30 Voluntariness and confidentiality were assured during the collection, handling and reporting
31
32 of data.^{26 27} The study was approved by the Regional Committee for Medical Research Ethics
33
34 (REK South-East 2011/2464).
35
36
37

38 39 **Patient involvement**

40
41 Before we started the study, we performed three pilot-interviews with cancer patients to test
42
43 the study design and interview-guide, and we made minor changes to the guide. These
44
45 interviews are not included in the study. No further patients' involvement was undertaken
46
47 when it comes to the specific aims or interpretation of the findings. The dissemination of the
48
49 findings will be this publication.
50
51
52
53
54
55

Findings

Through data-driven empirical analysis, we identified four themes: (1) insufficient initial information, (2) palliative chemotherapy and compassionate physicians and nurses offered hope, (3) the information given should be truthful and (4) professional, personal and organizational factors influenced information and communication. We did not identify any differences between participants receiving first- or second-line chemotherapy.

Insufficient initial information

The participants experienced receiving information about the incurable nature of their cancer differently, and the information was given in different settings. Some had to wait a long time (weeks or months) from their first worries about the disease until they could be examined or have an appointment at the hospital. When the cancer was finally diagnosed, they received limited apologies from the physicians because of the delay and emphasized that an excuse would have made the situation easier to handle. Some had not even felt particularly ill, and it was hard for them to understand the message about having an incurable disease when the doctor informed them. Most participants were informed about their diagnosis by surgeons, except for two who were informed by their general practitioners (GPs). Several participants experienced the first information about the incurable nature of their disease as a shock.

“When the surgeon gave me the message that my disease was incurable, I was shocked, I didn’t feel that anything was wrong. I asked him how long I had left to live. He just shrugged and didn’t have any answer. The conversation took 8 minutes.” (patient 4, woman aged 54 years).

Some participants reported that surgeons or GPs had given the message in an inappropriate way, at an inappropriate place (e.g., in a small examination room). Further

1
2
3 questions from the participants were answered only to a limited extent, if at all. It was tough
4
5 to be told that their cancer could not be cured. The message was experienced as a death
6
7 sentence, and several participants felt left behind with unanswered questions.
8
9

10
11 *“It is important to tell the truth, but in an appropriate way. Go home and die. That is not*
12
13 *appropriate” (patient 4, woman aged 54 years)*
14
15

16
17 Although the message was brutal to hear, some participants admitted that a straightforward
18
19 message was probably the best way.
20
21

22 Some participants experienced that the information before and after the operation was
23
24 insufficient. They would have liked more answers and adequate communication with the
25
26 surgeon. A couple of participants received a message that complete tumour resection was
27
28 impossible or that nearly nothing could be done
29
30

31
32 *“She (the surgeon) should not talk with people. Or learn a phrase telling the patients that*
33
34 *other HCPs will talk with you about this.” (patient 4, woman aged 54 years).*
35
36

37 On the other hand, some of the male participants in particular expressed satisfaction with how
38
39 the surgeon had given pre- and postoperative information and explained the operation, the
40
41 consequences and likely future treatment-related effects; e.g., challenges with the stoma or the
42
43 risk of impotence after the operation.
44
45
46
47
48

49 **Palliative chemotherapy and compassionate physicians and nurses offered hope**

50
51 When the participants started their post-surgery chemotherapy at the cancer centre further
52
53 treatment implied hope that something could be done. At the cancer centre the participants
54
55

1
2
3 were met with openness, knowledge and enough time. Nurses and physicians gave hope, and
4
5 the palliative treatment itself was also perceived as giving hope.
6
7

8
9 *“When I received the appointment for palliative chemotherapy I was relieved, something*
10
11 *could be done” (patient 3, woman aged 74 years)*
12
13

14
15 Furthermore, the participants emphasized the importance of including hope in patient
16
17 communication.
18
19

20
21
22 *“She looks at you. She gives hope. That is how I want to be met” (Patient 4, woman aged 54*
23
24 *years)*
25
26

27
28 The participants’ hope seemed to change from before they were diagnosed with their
29
30 incurable disease and through their disease trajectory. Even though they recognized that their
31
32 cancer was incurable, most hoped that they would be among those who could live for years
33
34 despite poor a prognosis. As the disease progressed, they hoped for good days, not
35
36 extraordinary things, or experiences. They just wanted ordinary everyday lives and the
37
38 possibility of being together with family and friends. The participants wanted to continue to
39
40 live and to see how things turned out.
41
42

43
44
45 *“I look forward to spring when the wagtail comes back outside my house” (patient 1, man*
46
47 *aged 67 years).*
48
49

The information given should be truthful

Correct and truthful information about their disease, treatment effects, side-effects, metastases, and likely future perspectives was important for the participants. They preferred to receive the test results immediately rather than to wait until their next appointment at the cancer centre.

«There were minor changes after the last computer tomography. The oncologist telephoned and told the results. I didn't have to wait for the next appointment, I didn't have to worry until then» (patient 17, woman aged 71 years)

Preferences regarding the amount of information that the participants wanted to receive at the time varied. Some participants wanted a total overview of their disease and prognosis from the start, some wanted a smaller amount of information at the time, while others wanted their body to tell them how their disease progressed.

«I don't want to know the exact date. I would like information about disease progress and prognosis bit by bit, or let my body tell me bit by bit» (patient 17, woman aged 71 years)

Most participants found vague information confusing, and in particular some of the male participants wanted straightforward information.

«I would like to know even more if it is possible. I don't want them to keep any information back. I would like to have a better overview and know what to expect in the future.» (patient 13, man aged 68 years)

1
2
3 Most participants felt that they had received honest information and answers and had
4 opportunities to ask questions. Some felt insecure if they were treated by a junior physician
5 who could not answer all their questions.
6
7

8
9
10 *“I would have felt safer if I was treated by a specialist, one who didn’t have to ask colleagues*
11 *to be sure. At least occasionally.” (patient 11, man aged 60 years).*
12
13

14
15 The participants experienced receiving information about their life expectancy at the cancer
16 centre differently. Some found the information to be sufficient and adequate, while other
17 claimed that they had been given very little specific information on this point, if anything at
18 all.
19

20
21
22 *“They haven’t said much about life expectancy. However, the treatment is palliative. They*
23 *haven’t given me the time. And I haven’t asked » (patient 7, man aged 63 years)*
24
25

26
27
28 Some participants would have liked to know the exact prognosis and time, partly because they
29 wanted to be able to “talk the serious talk” with their closest relatives and to be prepared to
30 die. This was especially important to participants with children or vulnerable relatives. A
31 couple of the participants expressed gratitude that the oncologists had told them their true
32 prognosis even though they did not ask for it.
33
34
35
36
37
38
39
40
41
42

43 **Professional, personal, and organizational factors influenced information and** 44 **communication** 45

46
47 Most participants wanted their health care and treatment to be organized in such a way that it
48 was possible to see the same physician at each consultation. Some of those who had to
49 alternate between different physicians felt that they had to start from the beginning each time
50 and felt it to be exhausting.
51
52
53
54
55

1
2
3 *“I am an introverted person. I am not able to speak openly with everyone. When I meet a new*
4 *physician, I have to start from the beginning, and I don’t like it. And it is OK to feel like this.*
5 *We are all different.” (patient 2, woman aged 73 years).*
6
7
8
9

10 In addition to the discomfiting feeling of having to deal with new physicians, some
11 participants reported that messages had not been forwarded between the different physicians,
12 resulting in mistakes. They felt that no one was in charge of their medical care and felt
13 insecure; for example, when experiencing changes in treatment when they changed
14 physicians/junior doctors. Some of the oldest participants also expressed difficulties in
15 understanding foreign physicians because of language problems. However, they felt
16 comforted that their treatment was discussed in the oncologist collegium. The nurses’ and
17 physicians’ professional knowledge and ability to answer questions inspired confidence.
18
19
20
21
22
23
24
25
26

27 A combination of professional knowledge and personality was emphasized as
28 important. Furthermore, the participants highly appreciated physicians and nurses with
29 enough time, who knew them and their disease. One participants characterized this as follows.
30
31
32
33
34

35 *“She is an oncologist with a heart and a brain.” (patient 4, woman 54 years).*
36
37

38 The participants preferred nurses and physicians who telephoned to ask how they felt and
39 gave test results or messages if any. At the same time, they appreciated the possibility of
40 contacting the physicians and nurses at the cancer centre if needed, to have “an open door”.
41
42 They wanted physicians and nurses who could see them as a person, not just a patient. The
43 importance of paying attention, making them feel that there was time enough for discussions
44 during the consultations or visits at the cancer centre for chemotherapy, and knowing them
45 without consulting the computer record was emphasized.
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 *“He saw the person. It was the warmth in his eyes and the way that he sat relaxed in his*
4 *chair. I don’t remember anything from the consultation. I just remember the feeling.” (patient*
5 *18, woman aged 34 years).*
6
7
8
9

10 The participants wanted to see physicians and nurses with a holistic approach to treatment and
11 care, who also wanted to take part in their life-world, not just the physical and mechanical
12 components related to their disease: in other words, they wanted a compassionate physician or
13 nurse. Furthermore, characteristics of the best physicians or nurses were emphasized as
14 knowledge, warmth, and trust. These characteristics were important for how participants felt,
15 for their hopes and for how they handled their disease.
16
17
18
19
20
21
22
23
24
25
26

27 **Discussion**

28
29 To our best knowledge this is the first study to explore palliative colorectal cancer patients’
30 thoughts about how disease information, prognoses and life expectancy were communicated,
31 from the first time that they were informed about the incurable nature of the disease
32 *throughout* to post-surgery palliative treatment. Our findings reveal that there seem to be a
33 change during the disease trajectory. Most of our participants experienced the first
34 information of their incurable disease as insufficient. Later on, post-surgery palliative
35 chemotherapy implied hope. The participants preferred truthful information about the
36 treatment and likely future perspectives. They wanted their treatment and care to be organized
37 in a way that they could see the same well-qualified and compassionate physicians each
38 consultation, and the same compassionate nurses when visiting the cancer centre for
39 chemotherapy. To deepen our understanding of the participants’ experiences and reflections,
40 we will discuss the findings in light of previous studies of patient–HCP communications of
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55

1
2
3 disease and life expectancy in patients with incurable cancer, applying Løgstrup's¹⁹
4 philosophy and Mishler's²⁰ focus on the patients' voice of their own life-world in patient-
5 physician communication. We will also suggest some implications for HCPs and
6 organizations in terms of cancer treatment and care.
7
8
9

10
11 The physicians who informed the participants about their incurable cancer might be
12 considered as the bearers of bad news. Initially, the participants were most likely to be in a
13 vulnerable situation, and the relationships between the physician and the participants in these
14 meetings were asymmetrical. The physician held the knowledge and expertise of the disease,
15 and the participants had to trust them.^{8 28} As Løgstrup¹⁹ underlines, this makes them expose
16 themselves to the situation, the message and the follow-up communication.^{29 30} According to
17 our participants' experiences, the information and communication in these meetings did not
18 give them sufficient help to handle the message and their vulnerable situation in an
19 appropriate way. They wanted to interact with physicians who were able to give the message
20 in a sensible and sensitive way, and who were able to have more answers and give enough
21 time.³¹ Additionally, as pointed out in the study by Barnett et al.¹⁸, doctors in surgical
22 specialities are significantly more likely to be rated poorly than non-surgical specialists or
23 GPs when breaking bad news.
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38

39 For the participants in the present study palliative treatment implied hope that
40 something could be done. Previous studies have also underlined how palliative treatments
41 imply hope. Hope is an important coping strategy in such patients,^{32 33} and has been
42 described as essential in human life, and important for a person's quality of life and well-
43 being.³³ Hope is the confident but uncertain expectation of a good future that appears to be
44 realistically possible and is personally significant to the individual.³⁴ The realistic hope for
45 most of our participants was that something could be done to relieve their symptoms and
46 potentially to postpone death, and to enable ordinary everyday lives and the possibility of
47
48
49
50
51
52
53
54
55

1
2
3 spending time with family and friends. Furthermore, the patients emphasized the importance
4 of including hope in HCPs' communication of disease, prognosis and life expectancy
5 throughout the disease trajectory. Previous studies show that there is a fine balance between
6 telling the truth and nurturing hope,^{15 35} and there is a spectrum of hope, from hope for a cure
7 to hope for living as normally as possible,^{15 35} which was also identified in our study.
8
9
10
11
12

13 It was a diversity of how detailed information the participants wanted about their
14 disease and likely future perspectives. Some wanted the information bit by bit, while other
15 preferred a total overview. Previous studies indicate that patients with incurable cancer want
16 truthful information about their disease, treatment, and likely future perspectives.^{36 37}
17 However, there are individual preferences, and individual customized approaches seem to be
18 necessary.^{38 39} The individual variety and preferences of our participants might be considered
19 as an important part of their life-world, which should be attended to in communication
20 between patients and physicians or nurses.¹⁹ Additionally, coping orientation (problem-
21 focused or emotion-focused),³¹ along with previous experiences, personality traits and
22 perhaps robustness, might have influenced how our participants experienced and preferred the
23 information and communication. All the participants in the present study were aware of the
24 incurable nature of their disease. However, we did not explore their accurate prognostic
25 awareness, which was the main focus of the systematic review and meta-regression analysis
26 by Chen et al.⁹
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43

44 An organization of palliative treatment and care with the same well-qualified
45 physician or nurse each time they visited the cancer centre was emphasized as being
46 important for the participants to be able to feel safe and to increase the possibility of
47 individual and customized care, and to be able to open up their inner thoughts. The
48 participants seemed to prefer physician or nurse communications to include what Mishler³⁰
49 has characterized as the “voice of medicine”, which mainly focuses on the symptoms and
50
51
52
53
54
55

1
2
3 medical and technical problems or aspects of the disease, and they also wanted physicians and
4
5 nurses to initiate communication focusing on the participants' inner thoughts related to their
6
7 illness—what Mishler³⁰ calls the “voice of lifeworld”— including more open-ended
8
9 questions. Such physicians and nurses might be characterized as compassionate caregivers.⁴⁰
10
11

12 13 14 15 **Implications for health care**

16
17 It might be considered to be overly demanding and tough to be the bearer of bad news of an
18
19 incurable disease. Some of our participants even pointed out that surgeons who are unable to
20
21 give the message in an appropriate way should not communicate with patients. Rogg et al.⁸
22
23 showed in their study that the Norwegian guidelines and training for physicians
24
25 communication of bleak prognosis were not sufficient. Further, they found that most
26
27 physicians reported that their education for such communication was achieved mainly through
28
29 observing colleagues and training.⁸ This indicates that it is a need for increased focus on
30
31 communication both during university studies and in hospitals.
32
33

34
35 Physicians and nurses have extensive responsibilities in how they communicate with
36
37 patients with incurable disease, particularly because of the asymmetrical relationship between
38
39 patients and HCPs. The HCPs have knowledge of how the disease will most likely progress,
40
41 and also common psychological responses. However, the patients' inner thoughts and life-
42
43 world are not necessarily known to the HCP. The responsibility to invite or initiate
44
45 communication on patients' inner thoughts and to start communication focusing on these
46
47 issues, is in the hands of physicians and nurses. Furthermore, it is important to strive for a
48
49 more symmetrical relationship between patients and HPCs,^{19 28} which will also increase the
50
51 possibility of shared decision-making in treatment and care.
52
53
54
55

1
2
3 Throughout their disease trajectory, the participants in our study preferred
4 individualized and customized information and communication. Physicians and nurses have to
5 be aware of, and to focus on, this whenever they inform and communicate with patients about
6 their disease and life expectancy. This requires not only communication skills but also enough
7 knowledge of the medical and psychological issues related to the disease and how these might
8 progress.
9

10
11 The participants preferred compassionate physicians and nurses. Being compassionate
12 requires more than empathy; it requires knowledge, proactivity and interconnectedness.⁴⁰
13 Furthermore, to become a compassionate physician or nurse, training is required through
14 observation, guidance and feedback on one's own practice.⁴⁰ HCPs also need to be aware of
15 how much information each patient prefers, and this awareness is associated with years of
16 practice and confidence.⁸ In addition, the treatment and care of patients undergoing palliative
17 chemotherapy should be organized in such a way that patients are able to see the same well-
18 qualified physicians and optionally also the same nurses at each consultation or visit at the
19 cancer centre.
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37

38 **Methodological considerations**

39
40 The strengths of the study are that the 20 participants provided us with rich data about their
41 experiences, feelings and reflections upon HCPs' information and communication of disease
42 and life expectancy during their disease trajectory. The authors are two nurses and a
43 gynaecologist treating patients with cancer, all with clinical experience and knowledge in
44 treating and caring for several patient groups within palliative care, which were used in the
45 discussion of the findings. Qualitative content analysis aims to stay close to the data and texts
46
47
48
49
50
51
52
53
54
55

1
2
3 to reveal the findings; however, the researchers' pre-understanding might also have
4
5 influenced the analysis of the data.
6

7 We studied patients with one type of cancer who were in the palliative phase, which
8
9 can be seen as a strength. Colorectal cancer is the second most common cancer diagnosed in
10
11 women worldwide, and the third most common cancer diagnosed in men^{21 22}, and the
12
13 knowledge could be applied to the patient group. On the other hand, studying just one patient
14
15 group might also limit the variance in findings that more heterogeneous groups might have
16
17 brought. Although our findings might not be generalizable to patients with other cancer
18
19 diagnoses, the findings can be transferable to hospitals with similar organisation of surgery
20
21 and post-surgery palliative treatments.
22
23
24
25
26
27

28 **Conclusions**

29
30 These findings provide a deeper knowledge of how patients with incurable colorectal cancer
31
32 in the palliative phase experience and reflect upon HCP–patient communications on disease
33
34 and life expectancy from before the surgery through to post-surgery chemotherapy. While the
35
36 first receipt of information of having an incurable disease was experienced as insufficient,
37
38 post-surgery palliative chemotherapy offered some hope. The participants preferred
39
40 individualized information about the treatment and likely future perspectives, and HCPs with
41
42 a holistic approach, including an ability to focus on their life-world with compassion.
43
44
45
46
47
48
49
50
51
52
53
54
55

Authors 'contributions

GR and IV were responsible for the study design

GR was responsible for the patient interviews and data collection

GR, US and IV contributed to a critical appraisal of the analyses, manuscript preparation and have read and approved the final version of the manuscript.

Competing interests: The authors declare that they have no competing interests.

Acknowledgement: We thank the Department of Clinical Research at Sorlandet Hospital and the Faculty of Health and Sport Science, University of Agder for funding the study.

Gudrun Rohde was a visiting researcher, as an Affiliate Academic, in the Marie Curie Palliative Care Research Department, University College London, January-June 2017 while writing most of the paper. We wish to thank the three patients who helped us in designing the study. We also want to thank all the patients who participated.

Funding: No further funding to disclose

Data sharing statement: All data are published, and therefore there is no additional data available. Owing to the sensitive nature of the information and appropriate medical ethics, access to the raw data set will be reviewed on request.

References

1. McRee AJ, Goldberg RM. Optimal management of metastatic colorectal cancer: current status. *Drugs* 2011;71(7):869-84.
2. Cameron J, Waterworth S. Patients' experiences of ongoing palliative chemotherapy for metastatic colorectal cancer: a qualitative study. *International journal of palliative nursing* 2014;20(5):218-24. [published Online First: 2014/05/24]
3. Cameron MG, Kersten C, Guren MG, et al. Palliative pelvic radiotherapy of symptomatic incurable prostate cancer - a systematic review. *Radiother Oncol* 2014;110(1):55-60. doi: 10.1016/j.radonc.2013.08.008 [published Online First: 2013/09/21]
4. Cameron MG, Kersten C, Vistad I, et al. Palliative pelvic radiotherapy for symptomatic rectal cancer - a prospective multicenter study. *Acta Oncol* 2016;55(12):1400-07. doi: 10.1080/0284186x.2016.1191666 [published Online First: 2016/06/23]
5. Hancock K, Clayton JM, Parker SM, et al. Truth-telling in discussing prognosis in advanced life-limiting illnesses: a systematic review. *Palliat Med* 2007;21(6):507-17. doi: 10.1177/0269216307080823 [published Online First: 2007/09/12]
6. Hagerty RG, Butow PN, Ellis PM, et al. Communicating prognosis in cancer care: a systematic review of the literature. *Ann Oncol* 2005;16(7):1005-53. doi: 10.1093/annonc/mdi211 [published Online First: 2005/06/09]
7. Chou WS, Hamel LM, Thai CL, et al. Discussing prognosis and treatment goals with patients with advanced cancer: A qualitative analysis of oncologists' language. *Health expectations : an international journal of public participation in health care and health policy* 2017;20(5):1073-80. doi: 10.1111/hex.12549 [published Online First: 2017/03/07]
8. Rogg L, Aasland OG, Graugaard PK, et al. Direct communication, the unquestionable ideal? Oncologists' accounts of communication of bleak prognoses. *Psychooncology* 2010;19(11):1221-28.
9. Chen CH, Kuo SC, Tang ST. Current status of accurate prognostic awareness in advanced/terminally ill cancer patients: Systematic review and meta-regression analysis. *Palliat Med* 2017;31(5):406-18. doi: 10.1177/0269216316663976 [published Online First: 2016/08/06]
10. Martinsson L, Axelsson B, Melin-Johansson C. Patients' perception of information from physicians during palliative chemotherapy: a qualitative study. *Psychooncology* 2016;14(5):495-502. doi: 10.1017/S1478951515001200

11. Murray CD, McDonald C, Atkin H. The communication experiences of patients with palliative care needs: A systematic review and meta-synthesis of qualitative findings. *Palliative & supportive care* 2015;13(2):369-83. doi: 10.1017/s1478951514000455 [published Online First: 2014/05/03]
12. Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. *BMJ* 2004;328(7452):1343. doi: 10.1136/bmj.38103.423576.55 [published Online First: 2004/05/21]
13. Butow PN, Dowsett S, Hagerty R, et al. Communicating prognosis to patients with metastatic disease: what do they really want to know? *Support Care Cancer* 2002;10(2):161-8. doi: 10.1007/s005200100290 [published Online First: 2002/02/28]
14. Clarke MG, Kennedy KP, MacDonagh RP. Discussing life expectancy with surgical patients: do patients want to know and how should this information be delivered? *BMC medical informatics and decision making* 2008;8:24. doi: 10.1186/1472-6947-8-24 [published Online First: 2008/06/17]
15. Clayton JM, Butow PN, Arnold RM, et al. Fostering coping and nurturing hope when discussing the future with terminally ill cancer patients and their caregivers. *Cancer* 2005;103(9):1965-75. doi: 10.1002/cncr.21011 [published Online First: 2005/03/25]
16. Stajduhar KI, Thorne SE, McGuinness L, et al. Patient perceptions of helpful communication in the context of advanced cancer. *J Clin Nurs* 2010;19(13-14):2039-47. doi: 10.1111/j.1365-2702.2009.03158.x [published Online First: 2010/10/06]
17. Richardson J. Health promotion in palliative care: the patients' perception of therapeutic interaction with the palliative nurse in the primary care setting. *J Adv Nurs* 2002;40(4):432-40. [published Online First: 2002/11/08]
18. Barnett MM. Effect of breaking bad news on patients' perceptions of doctors. *Journal of the Royal Society of Medicine* 2002;95(7):343-7. [published Online First: 2002/07/02]
19. Løgstrup KE. The ethical demand. Notre Dame, Ill: University of Notre Dame Press 1997.
20. Mishler EG. The Discourse of Medicine - Dialectics of Medical Interviews 1984.
21. Jemal A, Center MM, DeSantis C, et al. Global patterns of cancer incidence and mortality rates and trends. *Cancer Epidemiol Biomarkers Prev* 2010;19(8):1893-907. doi: 10.1158/1055-9965.epi-10-0437 [published Online First: 2010/07/22]
22. Torre LA, Bray F, Siegel RL, et al. Global cancer statistics, 2012. *CA Cancer J Clin* 2015;65(2):87-108. doi: 10.3322/caac.21262 [published Online First: 2015/02/06]
23. Crabtree BF, Miller WL. Doing qualitative research. Thousand Oaks, Calif.: Sage 1999.
24. Rohde G, Kersten C, Vistad I, et al. Spiritual Well-being in Patients With Metastatic Colorectal Cancer Receiving Noncurative Chemotherapy: A Qualitative Study. *Cancer Nurs* 2016 doi: 10.1097/ncc.0000000000000385 [published Online First: 2016/04/22]
25. Polit DF. Essentials of nursing research: methods, appraisal, and utilization. Philadelphia: Lippincott Williams & Wilkins 2006.
26. Beauchamp TL, Childress JF. Principles of biomedical ethics. 7th ed. ed. New York: Oxford University Press 2013.
27. WMA Declaration of Helsinki. Ethical Principles for Medical Research Involving Human Subjects 2013 [Available from: <http://www.wma.net/en/30publications/10policies/b3/>].
28. Rogg L, Loge JH, Aasland OG, et al. Physicians' attitudes towards disclosure of prognostic information: a survey among a representative cross-section of 1605 Norwegian physicians. *Patient Educ Couns* 2009;77(2):242-7. doi: 10.1016/j.pec.2009.03.007 [published Online First: 2009/04/10]

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
29. Friedrichsen MJ, Strang PM, Carlsson ME. Breaking bad news in the transition from curative to palliative cancer care--patient's view of the doctor giving the information. *Support Care Cancer* 2000;8(6):472-8. [published Online First: 2000/11/30]
30. G ME. *The Discourse of Medicine - Dialectics of Medical Interviews*. New Jersey: Ablex Publishing Corporation, Norwood, New Jersey 1984.
31. Lazarus RS, Folkman S. *Stress, appraisal, and coping*. New York: Springer 1984.
32. Hegarty M. The Dynamic of Hope: Hoping in the Face of Death. *Progress in Palliative Care* 2001;9(2):42-46. doi: 10.1080/09699260.2001.11746903
33. Rustoen T. Hope and quality of life, two central issues for cancer patients: a theoretical analysis. *Cancer Nurs* 1995;18(5):355-61. [published Online First: 1995/10/01]
34. Dufault K, Martocchio BC. Symposium on compassionate care and the dying experience. Hope: its spheres and dimensions. *Nurs Clin North Am* 1985;20(2):379-91. [published Online First: 1985/06/01]
35. Clayton JM, Butow PN, Arnold RM, et al. Discussing life expectancy with terminally ill cancer patients and their carers: a qualitative study. *Support Care Cancer* 2005;13(9):733-42. doi: 10.1007/s00520-005-0789-4 [published Online First: 2005/03/12]
36. Miccinesi G, Bianchi E, Brunelli C, et al. End-of-life preferences in advanced cancer patients willing to discuss issues surrounding their terminal condition. *Eur J Cancer Care (Engl)* 2012;21(5):623-33. doi: 10.1111/j.1365-2354.2012.01347.x [published Online First: 2012/04/24]
37. Hagerty RG, Butow PN, Ellis PA, et al. Cancer patient preferences for communication of prognosis in the metastatic setting. *J Clin Oncol* 2004;22(9):1721-30. doi: 10.1200/jco.2004.04.095 [published Online First: 2004/05/01]
38. Mackenzie LJ, Carey ML, Paul CL, et al. Do we get it right? Radiation oncology outpatients' perceptions of the patient centredness of life expectancy disclosure. *Psychooncology* 2013;22(12):2720-8. doi: 10.1002/pon.3337 [published Online First: 2013/06/27]
39. Walczak A, Butow PN, Davidson PM, et al. Patient perspectives regarding communication about prognosis and end-of-life issues: how can it be optimised? *Patient Educ Couns* 2013;90(3):307-14. doi: 10.1016/j.pec.2011.08.009 [published Online First: 2011/09/17]
40. Larkin PJ. *Compassion - The Essence of Palliative and End-of-life Care*. First ed. New York: Oxford University Press 2016.

Table 1: Characteristics of patients receiving non-curative chemotherapy.

	First-line (<i>n</i> = 12)	Second-line (<i>n</i> = 8)
Women	5	3
Men	7	5
Mean age (range), years	63 (34–75)	69 (64–75)
Marital status:		
Married/cohabiting	10	8
Single	1	
Widow/widower	1	
Chemotherapy used:		
Fliri/bevacizumab	10	
Flox (5-fluorouracil, folinic acid, axaliplatin)	1	8
Capecitabine plus oxaliplatin (Xelox)	1	

All patients received 5-fluorouracil-based combination chemotherapy with irinotecan or oxaliplatin, +/- bevacizumab.

Table 1

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	G Rohde (All interviews), p 7
2.	Credentials	PhD and professors, p 1
3.	Occupation	Professors, p 1
4.	Gender	All female, p 7
5.	Experience and training	All were trained researchers, p 7
Relationship with participants		
6.	Relationship established	No relationship before the interviews, p 7
7.	Participant knowledge of the interviewer	The participants did not know the interviewer, p 7
8.	Interviewer characteristics	Nurse and professor and had interests for the topic, p 7
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	Content analysis, p7
Participant selection		
10.	Sampling	The patients physicians asked if the researcher could contact them for inclusion, p 6
11.	Method of approach	Face-to-face, p 7
12.	Sample size	Twenty patients (Twelve men and eight women), p 6

No	Item	Guide questions/description
13.	Non-participation	We have limited information about this, p 6
Setting		
14.	Setting of data collection	Out-patient clinic and patients home (one patient), p 7
15.	Presence of non-participants	Non, p 6
16.	Description of sample	Patients with metastatic colorectal cancer receiving non-curative chemotherapy, p 6
Data collection		
17.	Interview guide	The interview guide was made by the researchers, p 7 and 8
18.	Repeat interviews	No repeated interviews were performed, p 7
19.	Audio/visual recording	Audio recording was used to collect the data, p 7
20.	Field notes	Field notes were made after the interviews, not stated in the manuscript
21.	Duration	50-100 minutes, p 7
22.	Data saturation	Data saturation was discussed and reached, p 7
23.	Transcripts returned	The transcripts were not returned to participants for comments, not stated in the manuscript
Domain 3: analysis and findings		
Data analysis		
24.	Number of data coders	one, p 8
25.	Description of the coding tree	The authors provided a description of the coding, p 8
26.	Derivation of themes	The themes were derived from the data, p 8

No	Item	Guide questions/description
27.	Software	none
28.	Participant checking	The participants did not provide feedback on the findings, not written in the manuscript
Reporting		
29.	Quotations presented	The quotations presented illustrate the themes / findings, p 9 - 14
30.	Data and findings consistent	There was consistency between the data presented and the findings p 8 - 14
31.	Clarity of major themes	Major themes were clearly presented in the findings, p 8
32.	Clarity of minor themes	No

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

BMJ Open

Communication of disease prognosis and life expectancy in patients with colorectal cancer undergoing palliative care: a qualitative study

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2018-023463.R2
Article Type:	Research
Date Submitted by the Author:	08-Oct-2018
Complete List of Authors:	Rohde, Gudrun; University of Agder, Faculty of Health and Sport Sciences; Sorlandet Hospital , Department of Clinical Research Söderhamn, Ulrika; University of Agder, Centre for Caring Research – Southern Norway, Department of Health and nursing Sciences, Faculty of Health and Sport Sciences Vistad, Ingvild ; Sorlandet Hospital Kristiansand , Obstetric and gynecology
Primary Subject Heading:	Palliative care
Secondary Subject Heading:	Communication
Keywords:	palliative care information, vulnerability, life-world, compassion

SCHOLARONE™
Manuscripts

1
2
3
4 **Communication of disease prognosis and life expectancy in patients with colorectal**
5 **cancer undergoing palliative care: a qualitative study**
6
7
8
9

10 **Authors:**

11 Gudrun Rohde, PhD (Corresponding author)

12 Professor, University of Agder, Faculty of Health and Sport Sciences and Department of

13 Clinical Research, Sorlandet Hospital Kristiansand

14 Postbox 422, 4604 Kristiansand, Norway

15 Phone: +47 99164094

16 Email: (gudrun.e.rohde@uia.no)

17
18
19
20
21
22
23
24
25
26
27
28 Ulrika Söderhamn, PhD

29 Professor

30 University of Agder, Faculty of Health and Sport Sciences

31 Postbox 509

32 4898 Grimstad, Norway

33 Phone: +47 416 98 753

34 Email: Ulrika.soderhamn@uia.no

35
36
37
38
39
40
41
42
43
44
45
46 Ingvild Vistad, MD PhD

47 Department of Obstetrics and Gynecology, Sorlandet Hospital HF, Kristiansand

48 Gynaecologist and Professor

49 Postbox 416, 4604 Kristiansand, Norway

50 Phone: +47 97532316

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Email: Ingvild.vistad@sshf.no

For peer review only

Abstract:

Objectives Patients with colorectal cancer undergoing palliative treatment receive extensive amounts of treatment-related information throughout their disease trajectory. We aimed to explore the experiences of patients with incurable colorectal cancer and their reflections upon information given by physicians and nurses while in palliative care. Our main focus was the patients' thoughts about how disease information and life expectancy were communicated, from the first time that they were informed about the incurable nature of their disease through to post-surgery palliative treatment.

Settings Patients with colorectal cancer receiving palliative chemotherapy.

Research design We used a qualitative approach, and the data were analysed according to qualitative content analysis.

Participants Twenty patients (34–75 years of age) were included in the study: 12 received first-line chemotherapy, and eight received second-line chemotherapy. Eleven patients were treated by oncologists, and nine were treated by junior physicians.

Results Through data-driven empirical analysis, we identified four themes: (1) insufficient initial information, (2) palliative chemotherapy and compassionate physicians and nurses offered hope, (3) the information given should be truthful and complete and (4) professional, personal and organizational factors influenced information and communication.

Conclusion Receiving the first information of having an incurable disease was experienced as insufficient, while post-surgery palliative chemotherapy offered hope. The patients preferred customized information about treatment and likely future perspectives, and physicians and nurses with a holistic approach focusing on their life-world with compassion. To be a sensitive, holistic, and compassionate physician or nurse requires knowledge and confidence. To achieve this, training and guidance at universities and in hospitals are needed.

Strengths and limitations of the study

- In dept and rich knowledge from 20 palliative colorectal cancer patients' thoughts about how disease information, prognoses and life expectancy were communicated, from the first time that they were informed about the incurable nature of the disease *through* to post-surgery treatment.
- The qualitative design gives insight into how palliative colorectal patients prefer health care professionals being compassionate throughout the entire disease trajectory.
- It can be seen as a limitation to focus on one group of patients in palliative care, because it can limit the variance in findings that more heterogeneous groups might have brought.
- We interviewed the patients during chemotherapy at one time point only and their memory about first information may have been coloured by later experiences.

Key words: palliative care information; vulnerability; life-world, compassion

Words: 4401 (revised 4170)

Background

Patients with cancer treated with palliative intent receive extensive amounts of disease-related information from the first time they are informed about the incurable nature of their disease, through the following months or even years with treatment and care.¹⁻⁴ Guidelines encourage health care professionals (HCPs) such as physicians and nurses to inform and discuss prognoses and likely future perspectives with the patients. However, many HCPs and patients struggle with the right approach for these discussions.⁵⁻⁷ On the other hand, primarily focusing on open communication regarding the bleak prospects of life expectancy entails a risk of overrunning the individual's information needs and hopes.⁸ In-depth studies on patients' experiences about information given by physicians throughout the disease trajectory are needed in order to guide HCP how to communicate palliative patients' diagnosis and life-expectancy.

Most studies focusing on patient–HCP communication of disease and prognosis in patients with incurable cancer are quantitative involving patients in an early stage of the disease.⁶ Qualitative studies show diverging results regarding the patient's acceptance of the chronic and incurable nature of their disease, and the presentation of their prognosis.⁹⁻¹⁵ Patients request both disease and illness oriented information by caring and trusting HCPs.¹¹

Patients with cancer in a palliative phase of treatment are vulnerable, and good patient–HCP relationships are important.¹⁶ The philosopher Løgstrup¹⁷ emphasized the importance of trust and the patients' vulnerability in such relationships. Furthermore, Mishler¹⁸ distinguished between the voice of medicine (the technical–scientific assumptions of medicine) and the voice of the life-world (the natural attitudes of everyday life), in patient–physician communication. He suggested an increased attentiveness to the voice of the patients in terms of their life-world, especially in vulnerable patients like patients in palliative care.

1
2
3 Patients with incurable cancer often experience a life crisis when they are informed
4 about the incurable nature of their cancer.¹⁹ Over time, the majority adjust to their new life
5 situation, and during this time, preferences and experiences regarding information and
6 communication might change.¹⁶ Colorectal cancer patients represent one of the most common
7 cancer types^{19 20} and there is limited knowledge of how this patient group look upon
8 information and communication of disease and life expectancy *throughout* the disease
9 trajectory as most studies include heterogeneous groups of patients. Therefore, we aimed to
10 explore the experiences of patients with incurable colorectal cancer and their reflections upon
11 information given by physicians and nurses while in palliative care. Our main focus was the
12 patients' thoughts about how disease information, prognoses and life expectancy were
13 communicated, from the first time that they were informed about the incurable nature of the
14 disease through to post-surgery palliative treatment.

31 **Methods**

32 We chose a qualitative inductive approach using in-depth interviews.²¹ As a part of a larger
33 study²² we invited patients with metastatic colorectal cancer who were referred for palliative
34 chemotherapy at three regional hospitals in Southern Norway. Oncologists informed patients
35 at the outpatient clinics about the study when they attended for the second or third cycle of
36 chemotherapy. Surgery is performed at the surgery department, with surgeons being
37 responsible for the patients in this phase. Chemotherapy is provided at an oncological
38 outpatient clinic with oncologists being responsible for the treatment.

39 The patients were eligible for inclusion if they were aged 18 years or older, had
40 metastatic colorectal cancer, were undergoing surgery for their cancer, had been referred for
41 first- or second-line palliative chemotherapy, had a life expectancy of >6 months and were

1
2
3 able to give written informed consent. We included patients of different ages, marital statuses
4 and other demographic and clinical characteristics.²³ We excluded patients with any
5
6 significant comorbidity that could compromise life expectancy, or inability to understand or
7
8 read Norwegian. Patients with conditions that the physician believed could affect the patient's
9
10 ability to understand or cope with the questions were not considered to be eligible, including
11
12 patients who were considered to be too emotionally vulnerable ($n = 4$). The patients were
13
14 included consecutively.
15
16

17
18 Twenty patients with colorectal cancer (34–75 years of age) were invited to participate
19
20 in the study over a period of 1 year, and all of them accepted the invitation. All patients
21
22 received combination chemotherapy (see Table 1) and had few physical symptoms related to
23
24 their disease. The sample comprised 12 patients receiving first-line chemotherapy (five
25
26 women and seven men) and eight receiving second-line chemotherapy (three women and five
27
28 men). Eleven patients were treated by oncologists, and nine were treated by junior physicians.
29
30

31
32 <Table 1 about here>
33
34

35 **Data collection**

36
37 The same researcher (GR) conducted all the interviews. At 2–4 days after the interview, GR
38
39 contacted the patient and asked whether the interview had influenced him or her negatively.
40
41 No patients experienced a negative influence or reaction. We performed in-depth interviews
42
43 lasting 50–100 minutes using a semi-structured interview guide to ensure that we included the
44
45 issues in focus²¹ and asked questions such as the following. “What do you think about the
46
47 first information that you received about your disease and the prognosis?” “How was the
48
49 information provided about the follow-up chemotherapy and likely future perspectives?”
50
51 “Have you received the information as you expected or is there anything missing?” “What are
52
53 important when giving disease information and prognosis, and how do you want it to be
54
55

1
2
3 given/delivered?” After the 11th interview, we did some preliminary analyses and made minor
4
5 changes to the interview guide to obtain more data on issues that needed to be expanded to
6
7 answer the research aim; for example, “What characterized the good information that you
8
9 received versus other information that you were not happy with?” Patients were included until
10
11 data saturation was achieved, indicated by minor new information in interview 19 and 20.²¹
12
13 One interview took place at the patient’s home. The other interviews took place at the cancer
14
15 centre or outpatient clinics, at a time when the patients had an appointment. The researchers
16
17 did not know the patients before the interviews and did not treat the patients.
18
19

20 21 **Analysis**

22
23 We audiotaped and transcribed the interviews verbatim and made logs after each interview.
24
25 The data were analysed according to qualitative content analysis to identify the themes in the
26
27 data. In the discussion, we interpreted our findings in light of the researchers’ previous
28
29 understanding and theory. GR and US are both nurses and professors in health sciences with
30
31 clinical experience in palliative care. IV is a gynaecologist and professor, also with extensive
32
33 experience in treating patients with cancer undergoing palliative care.
34
35

36
37 In the analyses, we (i) read all the interviews to understand the meaning of the whole
38
39 text, (ii) investigated sentences or sections to expose their meaning and to facilitate the
40
41 identification of themes, (iii) related sentences or sections to the meaning of the whole text
42
43 and (iv) identified passages representative of shared understandings between the researchers
44
45 and participants. To support the analysis, we created mind maps and discussed the analysis
46
47 among the authors. The analysis steps were followed carefully, which increases the reliability
48
49 of the study. Quotations have been used to illustrate and support the findings, and by that
50
51 increasing the trustworthiness. To validate the findings, all authors participated in discussions
52
53 of the empirical analysis and in writing up the findings.
54
55

Ethics

Voluntariness and confidentiality were assured during the collection, handling and reporting of data.^{24,25} The study was approved by the Regional Committee for Medical Research Ethics (REK South-East 2011/2464).

Patient involvement

Before we started the study, we performed three pilot-interviews with cancer patients to test the study design and interview-guide, and we made minor changes to the guide. These interviews are not included in the study. No further patients' involvement was undertaken when it comes to the specific aims or interpretation of the findings. The dissemination of the findings will be this publication.

Findings

Through data-driven empirical analysis, we identified four themes: (1) insufficient initial information, (2) palliative chemotherapy and compassionate physicians and nurses offered hope, (3) the information given should be truthful and complete and (4) professional, personal and organizational factors influenced information and communication. We did not identify any differences between participants receiving first- or second-line chemotherapy.

Insufficient initial information

The participants experienced receiving information about the incurable nature of their cancer differently, and the information was given in different settings. Some had to wait a long time (weeks or months) from their first worries about the disease until they were examined or had an appointment at the hospital. When the cancer was finally diagnosed, they received limited apologies from the physicians because of the delay and emphasized that an apology would

1
2
3 have made the situation easier to handle. Some had not even felt particularly ill, and it was
4
5 hard for them to understand the message about having an incurable disease when the
6
7 physician informed them. Most participants were informed about their diagnosis by surgeons,
8
9 except for two who were informed by their general practitioners (GPs). Several participants
10
11 experienced the first information about the incurable nature of their disease as a shock.
12
13

14
15 *“When the surgeon gave me the message that my disease was incurable, I was shocked, I*
16
17 *didn’t feel that anything was wrong. I asked him how long I had left to live. He just shrugged*
18
19 *and didn’t have any answer. The conversation took 8 minutes” (patient 4, woman aged 54*
20
21 *years).*
22
23

24
25 Some participants reported that surgeons or GPs had given the message in an
26
27 inappropriate way, at an inappropriate place (e.g., in a small examination room). Further
28
29 questions from the participants were answered only to a limited extent, if at all. It was tough
30
31 to be told that their cancer could not be cured. The message was experienced as a death
32
33 sentence, and several participants felt left behind with unanswered questions.
34
35

36
37 *“It is important to tell the truth, but in an appropriate way. Go home and die. That is not*
38
39 *appropriate” (patient 4, woman aged 54 years).*
40
41

42
43 Although the message was brutal to hear, some participants admitted that a straightforward
44
45 message was probably the best way.
46
47

48
49 Some participants experienced that the information before and after the operation was
50
51 insufficient. They would have liked more answers and adequate communication with the
52
53 surgeon. A couple of participants received a message that complete tumour resection was
54
55 impossible or that nearly nothing could be done. On the other hand, some of the male
56
57

1
2
3 participants in particular, expressed satisfaction with how the surgeon had given pre- and
4
5 postoperative information and explained the operation, the consequences and likely future
6
7 treatment-related effects; e.g., challenges with the stoma or the risk of impotence after the
8
9 operation.

10
11 *“I was happy with the information the surgeon gave. I am a person who ask questions, and I*
12
13 *am not afraid of asking. I received the answers I needed”.* (patient 15, man aged 73 years)

14 15 16 17 18 **Palliative chemotherapy and compassionate physicians and nurses offered hope**

19
20 When the participants started their post-surgery chemotherapy at the cancer centre further
21
22 treatment implied hope that something could be done. At the cancer centre the participants
23
24 were met with openness, knowledge and enough time. Nurses and physicians gave hope, and
25
26 the palliative treatment itself was also perceived as giving hope.
27
28

29
30
31 *“When I received the appointment for palliative chemotherapy I was relieved, something*
32
33 *could be done”* (patient 3, woman aged 74 years).

34
35
36
37
38 Furthermore, the participants emphasized the importance of including hope in patient
39
40 communication.
41
42

43
44
45 *“She looks at you. She gives hope. That is how I want to be met”* (Patient 4, woman aged 54
46
47 years).

48
49
50
51 The participants’ hope seemed to change from before they were diagnosed with their
52
53 incurable disease and through their disease trajectory. Even though they recognized that their
54
55

1
2
3 cancer was incurable, most participants hoped that they would be among those who could live
4 for years despite poor a prognosis. As the disease progressed, they hoped for good days, not
5 extraordinary things, or experiences. They just wanted ordinary everyday lives and the
6 possibility of being together with family and friends. The participants wanted to continue to
7 live and to see how things turned out.
8
9
10
11
12

13
14 *“I look forward to spring when the wagtail comes back outside my house” (patient 1, man*
15 *aged 67 years).*
16
17
18
19
20
21

22 **The information given should be truthful and complete**

23
24 Correct and truthful information about their disease, treatment effects, side-effects,
25 metastases, and likely future perspectives was important for the participants. They preferred
26 to receive the test results immediately rather than to wait until their next appointment at the
27 cancer centre.
28
29
30
31
32
33
34

35 *«There were minor changes after the last computer tomography. The oncologist telephoned*
36 *and told the results. I didn't have to wait for the next appointment, I didn't have to worry until*
37 *then» (patient 17, woman aged 71 years).*
38
39
40
41
42
43

44 Preferences regarding the amount of information that the participants wanted to
45 receive at the time varied. Some participants wanted a total overview of their disease and
46 prognosis from the start, some wanted a smaller amount of information at the time, while
47 others wanted their body to tell them how their disease progressed.
48
49
50
51
52
53
54
55

1
2
3 *«I don't want to know the exact date. I would like information about disease progress and*
4 *prognosis bit by bit, or let my body tell me bit by bit» (patient 17, woman aged 71 years).*
5
6
7

8
9 Most participants found vague information confusing. In particular, some of the male
10 participants wanted straightforward information.
11

12
13
14 *“I would like to know even more if it is possible. I don't want them to keep any information*
15 *back. I would like to have a better overview and know what to expect in the future.” (patient*
16 *13, man aged 68 years).*
17
18

19
20
21
22 Most participants felt that they had received honest information and answers and had
23 opportunities to ask questions. Some felt insecure if they were treated by a junior physician
24 who could not answer all their questions.
25

26
27
28
29 *“I would have felt safer if I was treated by a specialist, one who didn't have to ask colleagues*
30 *to be sure. At least occasionally” (patient 11, man aged 60 years).*
31
32

33
34 The participants experienced receiving information about their life expectancy at the cancer
35 centre differently. Some found the information to be sufficient and adequate, while other
36 claimed that they had received unspecific information on this point topic, if anything at all.
37
38

39
40
41
42
43 *“They haven't said much about life expectancy. However, the treatment is palliative. They*
44 *haven't given me the time. And I haven't asked» (patient 7, man aged 63 years).*
45
46

47
48
49 Some participants would have liked to know the exact prognosis and time, partly because they
50 wanted to be able to “talk the serious talk” with their closest relatives and to be prepared to
51 die. This was especially important to participants with children or vulnerable relatives. A
52
53
54

1
2
3 couple of the participants expressed gratitude that the oncologists had told them their true
4
5 prognosis even though they did not ask for it.
6
7

8 9 **Professional, personal, and organizational factors influenced information and** 10 11 **communication**

12
13 Most participants wanted their health care and treatment to be organized in such a way that it
14
15 was possible to see the same physician at each consultation. Some of those who had to
16
17 alternate between different physicians felt that they had to start from the beginning each time
18
19 and felt it to be exhausting.
20
21

22
23 *“I am an introverted person. I am not able to speak openly with everyone. When I meet a new*
24
25 *physician, I have to start from the beginning, and I don’t like it. And it is OK to feel like this.*
26
27 *We are all different” (patient 2, woman aged 73 years).*
28
29

30
31 In addition to the discomfiting feeling of having to deal with new physicians, some
32
33 participants reported that messages had not been forwarded between the different physicians,
34
35 resulting in misunderstandings. They felt that no one was in charge of their medical care and
36
37 felt insecure; for example, when experiencing changes in treatment when they changed
38
39 physicians/junior doctors. Further, some participants underlined that a lack of coordination in
40
41 treatment and care implied extra burden, and emphasized that better organization, and nurses’
42
43 and physicians’ professional knowledge and ability to answer questions inspired confidence.
44
45

46
47 A combination of professional knowledge and personality was emphasized as
48
49 important. Furthermore, the participants highly appreciated physicians and nurses with
50
51 enough time, who knew them and their disease. One participant characterized this as follows:
52

53
54 *“She is an oncologist with a heart and a brain” (patient 4, woman 54 years).*
55
56

1
2
3 The participants appreciated the possibility of contacting the physicians and nurses at the
4 cancer centre if needed, to have “an open door”. They wanted physicians and nurses who
5 could see them as a person, not just a patient. The importance of paying attention, making
6 them feel that there was time enough for discussions during the consultations or visits at the
7 cancer centre for chemotherapy, and knowing them without consulting the computer record
8 was emphasized.
9

10
11
12
13
14
15
16
17 *“He saw the person. It was the warmth in his eyes and the way that he sat relaxed in his*
18 *chair. I don’t remember anything from the consultation. I just remember the feeling” (patient*
19 *18, woman aged 34 years).*
20
21
22

23
24 The participants wanted to see physicians and nurses with a holistic approach to treatment and
25 care, who also wanted to take part in their life-world, not just the physical and mechanical
26 components related to their disease: in other words, they wanted a compassionate physician or
27 nurse. Furthermore, characteristics of the best physicians or nurses were emphasized as
28 knowledge, warmth, and trust. These characteristics were important for how participants felt,
29 for their hopes and for how they handled their disease.
30
31
32
33
34
35
36
37
38
39
40

41 **Discussion**

42
43 To our best knowledge, this is the first study to explore palliative colorectal cancer patients’
44 thoughts about communication of disease information, prognoses and life expectancy, from
45 the first time that they were informed about the incurable nature of the disease *throughout* to
46 post-surgery palliative treatment. To deepen our understanding of the participants’
47 experiences and reflections, we will discuss the findings in light of previous studies of
48 patient–HCP communications of disease and life expectancy in patients with incurable cancer.
49
50
51
52
53
54
55

1
2
3 We will apply Løgstrup's¹⁷ philosophy and Mishler's¹⁸ focus on the patients' voice of their
4 own life-world in patient-physician communication.
5
6

7 An asymmetric relationship where the physicians hold the knowledge and expertise of
8 the disease, and the participants have to trust them was evident in our findings. As Løgstrup
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

An asymmetric relationship where the physicians hold the knowledge and expertise of the disease, and the participants have to trust them was evident in our findings. As Løgstrup¹⁷ underlines, the patients expose themselves to the situation, the message and the follow-up communication. The participants wanted information about their incurable cancer in a sensible and sensitive way, in a setting with enough time. However, according to several of our participants, the communication in these meetings failed to give them sufficient help to handle the information and their vulnerability. Importantly, the physicians who informed the participants about their incurable cancer might be considered as bearers of bad news. Doctors in surgical specialities are significantly more likely to be rated poorly than non-surgical specialists or GPs when breaking bad news¹⁶.

For the participants in the present study, palliative chemotherapy implied hope that something could be done. Previous studies have also underlined that palliative treatment implies hope. Hope is an important coping strategy in such patients,^{26 27} and has been described as essential in human life. The realistic hope for most of our participants was that something could be done to relieve their symptoms and potentially to postpone death, and to enable ordinary everyday lives and the possibility of spending time with family and friends. Therefore, the patients emphasized the importance of including hope in HCPs' communication of disease, prognosis and life expectancy throughout the disease trajectory. Previous studies show that there is a fine balance between telling the truth and nurturing hope,^{14 28} and there is a spectrum of hope, from hope for a cure to hope for living as normally as possible,^{14 28} which was also identified in our study.

It was a diversity of how detailed information the participants wanted about their disease and likely future perspectives. Previous studies indicate that patients with incurable

1
2
3 cancer want truthful information about their disease, treatment, and likely future perspectives.
4
5 ^{29 30} However, there are individual preferences, and individual customized approaches seem to
6
7 be necessary. ^{31 32} The individual variety and preferences of our participants might be
8
9 considered as an important part of their life-world which should be attended to in
10
11 communication between patients and physicians or nurses. All the participants in the present
12
13 study were aware of the incurable nature of their disease. However, we did not explore their
14
15 accurate prognostic awareness, which was the main focus of the systematic review and meta-
16
17 regression analysis by Chen et al. ³³, who identified that only half of cancer patients with
18
19 advanced disease accurately understood their prognosis.
20
21

22 An organization of palliative treatment and care with the same well-qualified
23
24 physician or nurse each time they visited the cancer centre was emphasized as being
25
26 important for the participants. The participants seemed to prefer physician or nurse
27
28 communications to include what Mishler ¹⁸ has characterized as the “voice of medicine”,
29
30 which mainly focuses on the symptoms and medical and technical problems or aspects of the
31
32 disease, and they also wanted physicians and nurses to initiate communication focusing on the
33
34 participants’ inner thoughts related to their illness—what Mishler ¹⁸ calls the “voice of
35
36 lifeworld”— including more open-ended questions. Such physicians and nurses might be
37
38 characterized as compassionate caregivers. ³⁴
39
40
41
42
43
44
45

46 **Implications for health care**

47
48 It might be considered to be overly demanding and tough to be the bearer of bad news of an
49
50 incurable disease. Some of our participants even pointed out that surgeons who are unable to
51
52 give the message in an appropriate way should not communicate with patients. This indicates
53
54
55

1
2
3 that it is a need for increased focus on communication both during university studies and in
4
5 hospitals.

6
7 Physicians and nurses have extensive responsibilities in how they communicate with
8
9 patients with incurable disease, particularly because of the asymmetrical relationship between
10
11 patients and HCPs. The HCPs have knowledge of how the disease will most likely progress,
12
13 and also common psychological responses. However, the patients' inner thoughts and life-
14
15 world are not necessarily known to the HCP. The responsibility to invite or initiate
16
17 communication on patients' inner thoughts and to start communication focusing on these
18
19 issues, is in the hands of physicians and nurses. Furthermore, it is important to strive for a
20
21 more symmetrical relationship between patients and HCPs,^{17 28} which will also increase the
22
23 possibility of shared decision-making in treatment and care.

24
25
26 The participants preferred compassionate physicians and nurses. Being compassionate
27
28 requires more than empathy; it requires knowledge, proactivity and interconnectedness.³⁴
29
30 Furthermore, to become a compassionate physician or nurse, training is required through
31
32 observation, guidance and feedback on one's own practice.³⁴ HCPs also need to be aware of
33
34 how much information each patient prefers, and this awareness is associated with years of
35
36 practice and confidence.⁸ In addition, the treatment and care of patients undergoing palliative
37
38 chemotherapy should be organized in such a way that patients are able to see the same well-
39
40 qualified physicians and optionally also the same nurses at each consultation or visit at the
41
42 cancer centre.

43 44 45 46 47 48 49 **Methodological considerations**

50
51 The strengths of the study are that the 20 participants provided us with rich data about their
52
53 experiences, feelings and reflections upon HCPs' information and communication of disease
54
55

1
2
3 and life expectancy during their disease trajectory. The authors are two nurses and a
4
5 gynaecologist treating patients with cancer, all with clinical experience and knowledge in
6
7 treating and caring for several patient groups within palliative care, which were used in the
8
9 discussion of the findings. Qualitative content analysis aims to stay close to the data and texts
10
11 to reveal the findings; however, the researchers' pre-understanding might also have
12
13 influenced the analysis of the data.
14

15
16 We studied patients with one type of cancer who were in the palliative phase, which
17
18 can be seen as a strength. Colorectal cancer is the second most common cancer diagnosed in
19
20 women worldwide, and the third most common cancer diagnosed in men,^{19 20} and the
21
22 knowledge could be applied to the patient group. On the other hand, studying just one patient
23
24 group might also limit the variance in findings that more heterogeneous groups might have
25
26 brought. We have limited systematic information about the participants' sociodemographic,
27
28 common behavior and coping mechanisms that might have influenced their experiences and
29
30 preferences. However, based on the few characteristics as we identified during the interviews,
31
32 we found variations in socio-demographic factors such as gender, age, and marital status,
33
34 seems to be in accordance of patients with colorectal cancer as reported in Jemal A et al.¹⁹.
35
36 Although our findings might not be generalizable to patients with other cancer diagnoses, the
37
38 findings can be transferable to hospitals with similar organisation of surgery and post-surgery
39
40 palliative treatments.
41
42
43
44
45
46
47

48 **Conclusions**

49
50 These findings provide a deeper knowledge of how patients with incurable colorectal cancer
51
52 in the palliative phase experience and reflect upon HCP-patient communications on disease
53
54 and life expectancy from before the surgery through to post-surgery chemotherapy. While the
55

1
2
3 first receipt of information of having an incurable disease was experienced as insufficient,
4 post-surgery palliative chemotherapy offered some hope. The participants preferred
5 individualized information about the treatment and likely future perspectives, and HCPs with
6 a holistic approach, including an ability to focus on their life-world with compassion.
7
8
9
10
11
12
13
14

15 **Authors 'contributions**

16
17
18 GR and IV were responsible for the study design

19
20
21 GR was responsible for the patient interviews and data collection

22
23 GR, US and IV contributed to a critical appraisal of the analysis, manuscript preparation and
24 have read and approved the final version of the manuscript.
25
26
27
28
29
30

31 **Competing interests:** The authors declare that they have no competing interests.
32
33

34 **Acknowledgement:** We thank the Department of Clinical Research at Sorlandet Hospital and
35 the Faculty of Health and Sport Science, University of Agder for funding the study.
36
37

38 Gudrun Rohde was a visiting researcher, as an Affiliate Academic, in the Marie Curie
39 Palliative Care Research Department, University College London, January-June 2017 while
40 writing most of the paper. We wish to thank the three patients who helped us in designing the
41 study. We also want to thank all the patients who participated.
42
43
44
45
46
47
48

49 **Funding:** No further funding to disclose
50
51
52
53
54
55

Data sharing statement: All data are published, and therefore there is no additional data available. Owing to the sensitive nature of the information and appropriate medical ethics, access to the raw data set will be reviewed on request.

References

1. McRee AJ, Goldberg RM. Optimal management of metastatic colorectal cancer: current status. *Drugs* 2011;71(7):869-84.
2. Cameron J, Waterworth S. Patients' experiences of ongoing palliative chemotherapy for metastatic colorectal cancer: a qualitative study. *International journal of palliative nursing* 2014;20(5):218-24. [published Online First: 2014/05/24]
3. Cameron MG, Kersten C, Guren MG, et al. Palliative pelvic radiotherapy of symptomatic incurable prostate cancer - a systematic review. *Radiother Oncol* 2014;110(1):55-60. doi: 10.1016/j.radonc.2013.08.008 [published Online First: 2013/09/21]
4. Cameron MG, Kersten C, Vistad I, et al. Palliative pelvic radiotherapy for symptomatic rectal cancer - a prospective multicenter study. *Acta Oncol* 2016;55(12):1400-07. doi: 10.1080/0284186x.2016.1191666 [published Online First: 2016/06/23]
5. Hancock K, Clayton JM, Parker SM, et al. Truth-telling in discussing prognosis in advanced life-limiting illnesses: a systematic review. *Palliat Med* 2007;21(6):507-17. doi: 10.1177/0269216307080823 [published Online First: 2007/09/12]
6. Hagerty RG, Butow PN, Ellis PM, et al. Communicating prognosis in cancer care: a systematic review of the literature. *Ann Oncol* 2005;16(7):1005-53. doi: 10.1093/annonc/mdi211 [published Online First: 2005/06/09]
7. Chou WS, Hamel LM, Thai CL, et al. Discussing prognosis and treatment goals with patients with advanced cancer: A qualitative analysis of oncologists' language. *Health expectations : an international journal of public participation in health care and health policy* 2017;20(5):1073-80. doi: 10.1111/hex.12549 [published Online First: 2017/03/07]

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
8. Rogg L, Aasland OG, Graugaard PK, et al. Direct communication, the unquestionable ideal? Oncologists' accounts of communication of bleak prognoses. *Psychooncology* 2010;19(11):1221-28.
9. Martinsson L, Axelsson B, Melin-Johansson C. Patients' perception of information from physicians during palliative chemotherapy: a qualitative study. *Psychooncology* 2016;14(5):495-502. doi: 10.1017/S1478951515001200
10. Murray CD, McDonald C, Atkin H. The communication experiences of patients with palliative care needs: A systematic review and meta-synthesis of qualitative findings. *Palliative & supportive care* 2015;13(2):369-83. doi: 10.1017/s1478951514000455 [published Online First: 2014/05/03]
11. Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. *BMJ* 2004;328(7452):1343. doi: 10.1136/bmj.38103.423576.55 [published Online First: 2004/05/21]
12. Butow PN, Dowsett S, Hagerty R, et al. Communicating prognosis to patients with metastatic disease: what do they really want to know? *Support Care Cancer* 2002;10(2):161-8. doi: 10.1007/s005200100290 [published Online First: 2002/02/28]
13. Clarke MG, Kennedy KP, MacDonagh RP. Discussing life expectancy with surgical patients: do patients want to know and how should this information be delivered? *BMC medical informatics and decision making* 2008;8:24. doi: 10.1186/1472-6947-8-24 [published Online First: 2008/06/17]
14. Clayton JM, Butow PN, Arnold RM, et al. Fostering coping and nurturing hope when discussing the future with terminally ill cancer patients and their caregivers. *Cancer* 2005;103(9):1965-75. doi: 10.1002/cncr.21011 [published Online First: 2005/03/25]
15. Stajduhar KI, Thorne SE, McGuinness L, et al. Patient perceptions of helpful communication in the context of advanced cancer. *J Clin Nurs* 2010;19(13-14):2039-47. doi: 10.1111/j.1365-2702.2009.03158.x [published Online First: 2010/10/06]
16. Barnett MM. Effect of breaking bad news on patients' perceptions of doctors. *Journal of the Royal Society of Medicine* 2002;95(7):343-7. [published Online First: 2002/07/02]
17. Løgstrup KE. The ethical demand. Notre Dame, Ill: University of Notre Dame Press 1997.
18. Mishler, EG. The Discourse of Medicine - Dialectics of Medical Interviews. New Jersey: Ablex Publishing Corporation, Norwood, New Jersey 1984.
19. Jemal A, Center MM, DeSantis C, et al. Global patterns of cancer incidence and mortality rates and trends. *Cancer Epidemiol Biomarkers Prev* 2010;19(8):1893-907. doi: 10.1158/1055-9965.epi-10-0437 [published Online First: 2010/07/22]
20. Torre LA, Bray F, Siegel RL, et al. Global cancer statistics, 2012. *CA Cancer J Clin* 2015;65(2):87-108. doi: 10.3322/caac.21262 [published Online First: 2015/02/06]
21. Crabtree BF, Miller WL. Doing qualitative research. Thousand Oaks, Calif.: Sage 1999.
22. Rohde G, Kersten C, Vistad I, et al. Spiritual Well-being in Patients With Metastatic Colorectal Cancer Receiving Noncurative Chemotherapy: A Qualitative Study. *Cancer Nurs* 2016 doi: 10.1097/ncc.0000000000000385 [published Online First: 2016/04/22]
23. Polit DF. Essentials of nursing research: methods, appraisal, and utilization. Philadelphia: Lippincott Williams & Wilkins 2006.
24. Beauchamp TL, Childress JF. Principles of biomedical ethics. 7th ed. ed. New York: Oxford University Press 2013.
25. WMA Declaration of Helsinki. Ethical Principles for Medical Research Involving Human Subjects 2013 [Available from: <http://www.wma.net/en/30publications/10policies/b3/>].

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
26. Hegarty M. The Dynamic of Hope: Hoping in the Face of Death. *Progress in Palliative Care* 2001;9(2):42-46. doi: 10.1080/09699260.2001.11746903
27. Rustoen T. Hope and quality of life, two central issues for cancer patients: a theoretical analysis. *Cancer Nurs* 1995;18(5):355-61. [published Online First: 1995/10/01]
28. Clayton JM, Butow PN, Arnold RM, et al. Discussing life expectancy with terminally ill cancer patients and their carers: a qualitative study. *Support Care Cancer* 2005;13(9):733-42. doi: 10.1007/s00520-005-0789-4 [published Online First: 2005/03/12]
29. Miccinesi G, Bianchi E, Brunelli C, et al. End-of-life preferences in advanced cancer patients willing to discuss issues surrounding their terminal condition. *Eur J Cancer Care (Engl)* 2012;21(5):623-33. doi: 10.1111/j.1365-2354.2012.01347.x [published Online First: 2012/04/24]
30. Hagerty RG, Butow PN, Ellis PA, et al. Cancer patient preferences for communication of prognosis in the metastatic setting. *J Clin Oncol* 2004;22(9):1721-30. doi: 10.1200/jco.2004.04.095 [published Online First: 2004/05/01]
31. Mackenzie LJ, Carey ML, Paul CL, et al. Do we get it right? Radiation oncology outpatients' perceptions of the patient centredness of life expectancy disclosure. *Psychooncology* 2013;22(12):2720-8. doi: 10.1002/pon.3337 [published Online First: 2013/06/27]
32. Walczak A, Butow PN, Davidson PM, et al. Patient perspectives regarding communication about prognosis and end-of-life issues: how can it be optimised? *Patient Educ Couns* 2013;90(3):307-14. doi: 10.1016/j.pec.2011.08.009 [published Online First: 2011/09/17]
33. Chen CH, Kuo SC, Tang ST. Current status of accurate prognostic awareness in advanced/terminally ill cancer patients: Systematic review and meta-regression analysis. *Palliat Med* 2017;31(5):406-18. doi: 10.1177/0269216316663976 [published Online First: 2016/08/06]
34. Larkin PJ. *Compassion - The Essence of Palliative and End-of-life Care*. First ed. New York: Oxford University Press 2016.

Table 1: Characteristics of patients receiving non-curative chemotherapy.

	First-line (<i>n</i> = 12)	Second-line (<i>n</i> = 8)
Women	5	3
Men	7	5
Mean age (range), years	63 (34–75)	69 (64–75)
Marital status:		
Married/cohabiting	10	8
Single	1	
Widow/widower	1	
Chemotherapy used:		
Fliri/bevacizumab	10	
Flox (5-fluorouracil, folinic acid, axaliplatin)	1	8
Capecitabine plus oxaliplatin (Xelox)	1	

All patients received 5-fluorouracil-based combination chemotherapy with irinotecan or oxaliplatin, +/- bevacizumab.

Table 1

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	G Rohde (All interviews), p 7
2.	Credentials	PhD and professors, p 1
3.	Occupation	Professors, p 1
4.	Gender	All female, p 7
5.	Experience and training	All were trained researchers, p 7
Relationship with participants		
6.	Relationship established	No relationship before the interviews, p 7
7.	Participant knowledge of the interviewer	The participants did not know the interviewer, p 7
8.	Interviewer characteristics	Nurse and professor and had interests for the topic, p 7
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	Content analysis, p7
Participant selection		
10.	Sampling	The patients physicians asked if the researcher could contact them for inclusion, p 6
11.	Method of approach	Face-to-face, p 7
12.	Sample size	Twenty patients (Twelve men and eight women), p 6

No	Item	Guide questions/description
13.	Non-participation	We have limited information about this, p 6
Setting		
14.	Setting of data collection	Out-patient clinic and patients home (one patient), p 7
15.	Presence of non-participants	Non, p 6
16.	Description of sample	Patients with metastatic colorectal cancer receiving non-curative chemotherapy, p 6
Data collection		
17.	Interview guide	The interview guide was made by the researchers, p 7 and 8
18.	Repeat interviews	No repeated interviews were performed, p 7
19.	Audio/visual recording	Audio recording was used to collect the data, p 7
20.	Field notes	Field notes were made after the interviews, not stated in the manuscript
21.	Duration	50-100 minutes, p 7
22.	Data saturation	Data saturation was discussed and reached, p 7
23.	Transcripts returned	The transcripts were not returned to participants for comments, not stated in the manuscript
Domain 3: analysis and findings		
Data analysis		
24.	Number of data coders	one, p 8
25.	Description of the coding tree	The authors provided a description of the coding, p 8
26.	Derivation of themes	The themes were derived from the data, p 8

No	Item	Guide questions/description
27.	Software	none
28.	Participant checking	The participants did not provide feedback on the findings, not written in the manuscript
Reporting		
29.	Quotations presented	The quotations presented illustrate the themes / findings, p 9 - 14
30.	Data and findings consistent	There was consistency between the data presented and the findings p 8 - 14
31.	Clarity of major themes	Major themes were clearly presented in the findings, p 8
32.	Clarity of minor themes	No

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

BMJ Open

Reflections by patients with colorectal cancer undergoing palliative care on communication of disease prognosis and life expectancy by health care professionals

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2018-023463.R3
Article Type:	Research
Date Submitted by the Author:	23-Dec-2018
Complete List of Authors:	Rohde, Gudrun; University of Agder, Faculty of Health and Sport Sciences; Sorlandet Hospital , Department of Clinical Research Söderhamn, Ulrika; University of Agder, Centre for Caring Research – Southern Norway, Department of Health and nursing Sciences, Faculty of Health and Sport Sciences Vistad, Ingvild ; Sorlandet Hospital Kristiansand , Obstetric and gynecology
Primary Subject Heading:	Palliative care
Secondary Subject Heading:	Communication
Keywords:	palliative care information, vulnerability, life-world, compassion

SCHOLARONE™
Manuscripts

1
2
3 **New title: Reflections by patients with colorectal cancer undergoing palliative care on**
4 **communication of disease prognosis and life expectancy by health care professionals**
5
6
7
8
9

10 **Authors:**

11 Gudrun Rohde, PhD (Corresponding author)

12 Professor, University of Agder, Faculty of Health and Sport Sciences and Department of

13 Clinical Research, Sorlandet Hospital Kristiansand

14 Postbox 422, 4604 Kristiansand, Norway

15 Phone: +47 99164094

16 Email: (gudrun.e.rohde@uia.no)

17
18
19
20
21
22
23
24
25
26
27
28 Ulrika Söderhamn, PhD

29 Professor

30 University of Agder, Faculty of Health and Sport Sciences

31 Postbox 509

32 4898 Grimstad, Norway

33 Phone: +47 416 98 753

34 Email: Ulrika.soderhamn@uia.no

35
36
37
38
39
40
41
42
43
44
45
46
47 Ingvild Vistad, MD PhD

48 Department of Obstetrics and Gynecology, Sorlandet Hospital HF, Kristiansand

49 Gynaecologist and Professor

50 Postbox 416, 4604 Kristiansand, Norway

51 Phone: +47 97532316

52 Email: Ingvild.vistad@sshf.no
53
54
55
56
57
58
59
60

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Abstract:

Objectives Patients with colorectal cancer undergoing palliative treatment receive extensive treatment-related information throughout their disease trajectory. We aimed to explore the experiences of patients with incurable colorectal cancer while in palliative care and their reflections upon the information provided by physicians and nurses. Our main focus was the patients' thoughts about how information about disease status and life expectancy was communicated, from the first time that they were informed about the incurable nature of their disease through to post-surgery palliative treatment.

Settings Patients with colorectal cancer receiving palliative chemotherapy.

Research design We used a qualitative approach, and the data were analysed by qualitative content analysis.

Participants Twenty patients (34–75 years of age) were included in the study; 12 received first-line chemotherapy, and eight received second-line chemotherapy. Eleven patients were treated by oncologists, and nine were treated by junior physicians.

Results Data-driven empirical analysis identified three themes: (1) inadequate information during the initial phase of the disease trajectory; (2) hope and information further into the disease trajectory; and (3) personal, professional and organizational factors that influenced information and communication throughout the disease trajectory.

Conclusion The participants' experience of being told for the first time that they had an incurable disease was perceived as inadequate, while post-surgery palliative chemotherapy, physicians and nurses offered hope. The participants preferred customized information about their treatment and likely future prospects and physicians and nurses who took a holistic and compassionate approach focusing on their life-world. To be a sensitive, holistic and compassionate physician or nurse requires knowledge and confidence. To achieve this requires training and guidance at universities and in hospitals.

Strengths and limitations of the study

- In-depth and rich knowledge derived from the thoughts of 20 patients undergoing palliative care for colorectal cancer about how information about their disease, prognosis and life expectancy was communicated, starting from the first time that they were told that they had an incurable disease through to their post-surgery treatment.
- The qualitative design revealed that patients with colorectal cancer undergoing palliative care prefer health care professionals who are compassionate at all stages of their disease trajectory.
- It could be seen as a limitation that the study focused on one group of patients in palliative care, because this could limit the variation in findings that might have been evident with inclusion of more heterogeneous groups.
- We interviewed the patients at only one time point during chemotherapy and their memory about receiving their first information relating to their disease may have been coloured by later experiences.

Key words: palliative care information; vulnerability; life-world, compassion

Background

Patients with cancer who are treated with palliative intent receive extensive amounts of disease-related information from the first time they are informed about the incurable nature of their disease through the following months or years of treatment and care.¹⁻⁴ Guidelines encourage health care professionals (HCPs) such as physicians and nurses to keep patients informed and to discuss their prognoses and likely future prospects. However, many HCPs and patients struggle to find the right approach for these discussions,⁵⁻⁹ and a primary focus on open communication regarding the bleak prospects for the patient's life expectancy entails a risk of overwhelming the individual's need for information and their hope.¹⁰ In-depth studies of patients' experiences about information given by physicians and nurses throughout their disease trajectory are needed to guide HCPs in how to communicate to patients undergoing palliative care information about their diagnosis and life expectancy.

Most studies focusing on patient–HCP communications about disease and prognosis in patients with incurable cancer are quantitative and involve patients at either an early or late stage of the disease.^{6 11} Qualitative studies report divergent results regarding the patient's acceptance of the chronic and incurable nature of their disease and the presentation of their prognosis.¹¹⁻¹⁷ Patients request that both disease- and illness-oriented information be provided by caring and trusted HCPs.^{13 14 17}

Patients with cancer undergoing palliative treatment are vulnerable, and good patient–HCP relationships are important.¹⁸ The philosopher Løgstrup¹⁹ emphasized the importance of trust and the patients' vulnerability in such relationships, while Mishler²⁰ distinguished between the voice of medicine (the technical–scientific assumptions of medicine) and the voice of the life-world (the natural attitudes of everyday life) in patient–physician communication. Mishler suggested an increased attentiveness to the voice of the patients in

1
2
3 terms of their life-world, especially in vulnerable individuals such as patients in palliative
4
5 care.
6

7
8 Patients often experience a life crisis when they are informed that their cancer is
9
10 incurable.²¹ Over time, the majority adjust to their new life situation, and during this time,
11
12 their preferences and experiences regarding information and communication might *change*.¹⁸
13
14 Although colorectal cancer is one of the most common types of cancer,^{21 22} there is limited
15
16 knowledge about how this patient group views information and communication about disease
17
18 and life expectancy *throughout* their disease trajectory, because most studies include
19
20 heterogeneous groups of patients. Treatment for colorectal cancer usually involves surgical
21
22 removal of the tumour followed by adjuvant chemotherapy. Thus, most patients with
23
24 colorectal cancer tend to have a similar disease trajectory, and knowledge about their
25
26 experience and information preferences might be valuable to give patients better palliative
27
28 care.
29
30
31
32

33 We aimed to explore the experiences of patients with incurable colorectal cancer and
34
35 their reflections upon information provided by physicians and nurses while they were in
36
37 palliative care. Our main focus was the patients' thoughts about how information about their
38
39 disease, prognosis and life expectancy was communicated, from the first time that they were
40
41 told that their disease was incurable through to post-surgery palliative treatment.
42
43
44

45 **Methods**

46
47
48 We chose a qualitative inductive approach using in-depth interviews.²³ As part of a larger
49
50 study,²⁴ we invited patients with metastatic colorectal cancer who were referred for palliative
51
52 chemotherapy at three regional hospitals in Southern Norway to participate in this study.
53
54 Oncologists informed patients about the study at the outpatient clinics when they attended for
55
56 the second or third cycle of chemotherapy. Most participants were informed of their incurable
57
58 diagnosis by surgeons, except for two who were informed by their general practitioners (GPs).
59
60

1
2
3 All participants had undergone surgery for their cancer, and most had their surgery at
4 relatively small hospitals, with surgeons being mainly responsible for the patients' care and
5 the communication in this phase. The participants spent only a few days in the surgery
6 department with teams including few HCPs. Subsequently, chemotherapy was provided at an
7 oncological outpatient clinic where oncologists were mainly responsible for the treatment.
8
9
10
11
12
13
14
15 The participants visited the outpatient clinic for weeks or months.

16
17 The patients were eligible for inclusion if they were aged 18 years or older, had
18 metastatic colorectal cancer, had undergone surgery for their cancer, had been referred for
19 first- or second-line palliative chemotherapy, had a life expectancy of >6 months and were
20 able to give written informed consent. We included consecutive patients of different ages and
21 marital status and with varying demographic and clinical characteristics.²⁵ We excluded
22 patients with any significant comorbidity that could compromise their life expectancy, or who
23 were unable to understand or read Norwegian. Patients with conditions that the physician
24 believed could affect the patient's ability to understand or cope with the questions were
25 considered ineligible, including patients who were considered to be too emotionally
26 vulnerable ($n = 4$).

27
28
29
30
31
32
33
34
35
36
37
38
39
40 Twenty patients with colorectal cancer (34–75 years of age) were invited to participate
41 in the study over a period of 1 year, and all accepted the invitation. All patients received
42 combination chemotherapy (Table 1) and had few physical symptoms related to their disease.
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
841
842
843
844
845
846
847
848
849
850
851
852
853
854
855
856
857
858
859
860
861
862
863
864
865
866
867
868
869
870
871
872
873
874
875
876
877
878
879
880
881
882
883
884
885
886
887
888
889
890
891
892
893
894
895
896
897
898
899
900
901
902
903
904
905
906
907
908
909
910
911
912
913
914
915
916
917
918
919
920
921
922
923
924
925
926
927
928
929
930
931
932
933
934
935
936
937
938
939
940
941
942
943
944
945
946
947
948
949
950
951
952
953
954
955
956
957
958
959
960
961
962
963
964
965
966
967
968
969
970
971
972
973
974
975
976
977
978
979
980
981
982
983
984
985
986
987
988
989
990
991
992
993
994
995
996
997
998
999
1000

<Table 1 about here>

Data collection

The same researcher (GR) conducted all the interviews. One interview took place at the patient's home, and the other interviews took place at the cancer centre or outpatient clinics at a time when the patients had an appointment. The researchers did not know the patients before the interviews and did not treat the patients. The meetings were in-depth interviews lasting 50–100 minutes using a semi-structured interview guide to ensure inclusion of the issues in focus,²³ and questions such as: "What do you think about the first information that you received about your disease and its prognosis?", "How was information provided about the follow-up chemotherapy and likely future prospects?", "Have you received the information that you expected or is there anything missing?", and "What things are important when giving information about your disease and prognosis, and how do you want it to be given/delivered?" After conducting 11 interviews, we did some preliminary analyses and made minor changes to the interview guide to obtain more data on issues that needed to be expanded to address the research aim; for example, "What characterized the good information that you received versus other information that you were not happy with?" Patients were included until data saturation was achieved, as indicated by only minor new information being obtained in interviews 19 and 20.²³ At 2–4 days after each interview, GR contacted the patient and asked whether the interview had influenced him or her negatively. No patient experienced a negative influence or reaction.

Analysis

We audiotaped and transcribed the interviews verbatim and made logs after each interview. The data were analysed by qualitative content analysis to identify the themes in the data. For the analyses, we (i) read all the interviews to understand the meaning of the whole text, (ii) investigated sentences or sections to clarify their meaning and to facilitate the identification of themes, (iii) related sentences or sections to the meaning of the whole text and (iv) identified

1
2
3 passages representative of shared understanding between the researchers and participants. To
4
5 support the analysis, we created mind maps and discussed the analysis. The analysis steps
6
7 were followed carefully, which increased the reliability of the study. Quotations are used to
8
9 illustrate and support the findings, which increases their trustworthiness. To validate the
10
11 findings, all authors participated in discussions of the empirical analysis and in writing up the
12
13 findings. In the discussion, the findings were interpreted in light of our previous
14
15 understanding. GR and US are both nurses and professors in health sciences with clinical
16
17 experience in palliative care. IV is a gynaecologist and professor who also has extensive
18
19 experience in treating patients with cancer who are undergoing palliative care.
20
21
22

23 24 25 **Ethics**

26
27 Voluntariness and confidentiality were assured during the collection, handling and reporting
28
29 of data.^{26 27} The study was approved by the Regional Committee for Medical Research Ethics
30
31 (REK South-East 2011/2464).
32
33

34 35 **Patient involvement**

36
37 Before we started the study, we conducted three pilot interviews with cancer patients to test
38
39 the study design and the interview guide, and made minor changes to the guide. These
40
41 interviews were not included in the study. There was no further patients' involvement. The
42
43 findings are given in this publication.
44
45
46

47 48 **Findings**

49
50 Through data-driven empirical analysis, we identified three themes: (1) inadequate
51
52 information during the initial phase of the disease trajectory; (2) hope and information further
53
54 into the disease trajectory; and (3) personal, professional and organizational factors that
55
56 influenced information and communication throughout the disease trajectory. We did not
57
58 identify any differences between participants receiving first- or second-line chemotherapy.
59
60

Inadequate information during the initial phase of the disease trajectory

The news that their cancer was incurable was given to patients at the surgical department or by the patient's GP. Overall, how patients experienced receiving this information varied: it could have been given earlier, it was experienced as a shock, it was insufficient, it was given in an inappropriate way or at an inappropriate place. However, some reported that they were satisfied with the way the information was given.

A few participants had to wait a long time (weeks or months) from their first concern about the disease until they were examined or had an appointment at the hospital. When the cancer was finally diagnosed, they received limited apologies for the delay from the physicians, and emphasized that an apology would have made the situation easier to handle. Some had not even felt particularly ill, and it was hard for them to understand the message from the physician that they had an incurable disease. Several participants experienced the first information about the incurable nature of their disease as a shock.

“When the surgeon gave me the message that my disease was incurable, I was shocked, I didn't feel that anything was wrong. I asked him how long I had left to live. He just shrugged and didn't have any answer. The conversation took 8 minutes” (patient 4, woman aged 54 years).

We did not identify any difference between the two participants who received the news from their GP compared with those who received it from their surgeon.

Some participants felt that the information given before and after their surgery was insufficient. The information was brief, there was no time after the surgery for further communication, and a few participants felt that the HCPs had not told them the whole truth. They would have liked more answers and sufficient communication with the surgeon.

1
2
3 *“I think she gave the message in three sentences. She said I had metastatic cancer. That’s it. I*
4 *asked what it meant. ‘I don’t know’ she replied” (patient 6, man 73 years).*

5
6
7
8
9 In contrast, some of the participants, males in particular, expressed satisfaction with
10 how the surgeon had given pre- and postoperative information and explained the surgery, its
11 consequences and likely future treatment-related effects, e.g., challenges with the stoma or the
12 risk of impotence after the operation.

13
14
15
16
17
18
19 *“I was happy with the information the surgeon gave. I am a person who asks questions, and I*
20 *am not afraid of asking. I received the answers I needed” (patient 15, man aged 73 years).*

21
22
23
24
25 A few participants reported that surgeons or GPs had given them the news in an
26 inappropriate way or at an inappropriate place (e.g., in a small examination room) and they
27 experienced this as an extra burden. Further questions from the participants were answered to
28 a limited extent, if at all. It was challenging to be told that their cancer could not be cured. A
29 few participants received the message that a complete tumour resection was impossible or that
30 very little could be done. Such messages were experienced as a death sentence.

31
32
33
34
35
36
37
38
39 *“It’s important to tell the truth, but in an appropriate way. ‘Go home and die’. That’s not*
40 *appropriate” (patient 4, woman aged 54 years).*

41
42
43
44
45 Although the message was brutal to hear, a few participants admitted that a straightforward
46 message was probably the best way.

47 48 49 50 **Hope and information further into the disease trajectory**

51
52
53 Post-surgery chemotherapy and further information and care were offered/given at the cancer
54 centre. Hope was offered by the palliative chemotherapy itself, as well as by physicians and
55 nurses, and there was variation in how much and how precise information the participants
56 preferred in this phase.
57
58
59
60

1
2
3 When the participants started their post-surgery chemotherapy, some time had passed
4 and further treatment implied hope that something could be done after all. The behaviour and
5 attitudes of physicians and nurses also offered hope. At the cancer centre, the participants
6
7 were met with openness, knowledge and sufficient time. The participants experienced that the
8 physicians postponed death by offering chemotherapy, and the importance of including hope
9 in patient communication was emphasized.

10
11
12
13
14
15
16
17
18 *“She asked about my background, she saw more than my illness. She looks at you. She gives*
19 *you hope. That is how I want to be met” (Patient 4, woman aged 54 years).*

20
21
22
23
24 The participants’ hopes seemed to change from before they were diagnosed with their
25 incurable disease and through their disease trajectory. Physicians and nurses at the cancer
26 centre conveyed that they would try to delay disease progress and relieve pain and symptoms.
27 Even though they recognized that their cancer was incurable, most participants hoped that
28 they would be among those who could live for years despite a poor prognosis. As the disease
29 progressed, they hoped for good days, not extraordinary things or experiences, and for some
30 participants there seemed to be a change in goals and values.

31
32
33
34
35
36
37
38
39
40 Correct and truthful information about their disease, treatment effects, side effects,
41 metastases and likely future prospects was important for the participants. Preferences varied
42 regarding the amount of information they wanted to receive and at which time point. Some
43 participants wanted a total overview of their disease and prognosis from the start, some
44 wanted a smaller amount of information at that time, while others wanted their body to tell
45 them how their disease was progressing.

46
47
48
49
50
51
52
53
54 *“I don’t want to know the exact date. I would like information about disease progression and*
55 *prognosis bit by bit, or let my body tell me bit by bit” (patient 17, woman aged 71 years).*

1
2
3 Some participants found vague information about likely prospects confusing. In
4 particular, some of the male participants wanted straightforward information.
5
6
7

8
9 *“I would like to know even more if it is possible. I don’t want them to keep any information*
10 *back. I would like to have a better overview and know what to expect in the future” (patient*
11 *13, man aged 68 years).*
12
13
14

15
16 During palliative chemotherapy, the participants had different experiences of receiving
17 information about their life expectancy. Some found the information to be adequate, while
18 others claimed that they had received non-specific information on this topic, if anything at all.
19
20
21
22

23
24 *“They haven’t said much about life expectancy. However, the treatment is palliative. They*
25 *haven’t given me the time. And I haven’t asked” (patient 7, man aged 63 years).*
26
27
28

29 30 **Personal, professional and organizational factors that influenced information and** 31 **communication throughout the disease trajectory** 32

33
34 Throughout their disease trajectory, the participants had experiences and preferences relating
35 to personal, professional and organizational factors that influenced information and
36 communication. The participants experienced that in the surgery department, there was
37 limited time for information and communication. They preferred HCPs who were
38 knowledgeable and took a holistic approach, and that their health care be organized in such a
39 way that it was possible to meet the same well-qualified HCPs.
40
41
42
43
44
45
46
47

48
49 Most participants met the surgeon once before the surgery and spent only a few days
50 in the surgery department. Some experienced that there was too little time for information and
51 communication.
52
53
54
55
56
57
58
59
60

1
2
3 *“I only received a small amount of information at the surgical department. They just sent me*
4 *home. You’re finished, you can leave. I would have liked more answers” (patient 20, man 74*
5 *years).*
6
7
8
9

10
11 The combination of the professional knowledge and personality of the HCPs was
12 emphasized as important. The participants strongly appreciated physicians and nurses who
13 had enough time for them and who knew them and their disease. One participant
14 characterized this as follows.
15
16
17
18

19
20
21 *“She is an oncologist with a heart and a brain” (patient 4, woman 54 years).*
22
23

24
25 The participants wanted physicians and nurses who could see them as a person, not
26 just as a patient. They emphasized the importance of the HCP paying attention, making them
27 feel that there was time enough for discussions during the consultations or visits at the cancer
28 centre for chemotherapy, and knowing them without consulting the computer record.
29
30
31
32

33
34
35 *“He saw the person. It was the warmth in his eyes and the way that he sat relaxed in his*
36 *chair. I don’t remember much from the consultation. I just remember the feeling” (patient 18,*
37 *woman aged 34 years).*
38
39
40

41
42
43 The participants also wanted to see physicians and nurses who took a holistic approach
44 to treatment and care, who took part in their life-world, not just the physical and mechanical
45 components related to their disease; in other words, they wanted a compassionate physician or
46 nurse. Indeed, the characteristics of the best physicians or nurses were emphasized as
47 knowledge, warmth and trust, because such qualities were important for how the participants
48 felt, for their hopes and for how they dealt with their disease.
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 *“When I come to the cancer centre, I feel it’s about me. I know there are hundreds of people*
4 *coming and going. But every time I come, I feel that they are taking care of me” (patient 6,*
5
6 *man 72 years)*
7
8
9

10
11 The participants preferred to be treated by knowledgeable HCPs who were able to
12 answer questions. Some felt insecure if they were treated by a junior physician who could not
13 answer all their questions.
14
15
16

17
18
19 *“I would have felt more secure if I was treated by a specialist, one who didn’t have to ask*
20 *colleagues to be sure. At least occasionally” (patient 11, man aged 60 years).*
21
22

23
24 Furthermore, the participants preferred to receive their test results immediately rather
25 than to wait until their next appointment at the outpatient clinic or the cancer centre.
26
27
28

29
30 *“There were minor changes after the last computer tomography. The oncologist telephoned*
31 *and told me the results. I didn’t have to wait for the next appointment, I didn’t have to worry*
32 *until then” (patient 17, woman aged 71 years).*
33
34
35

36
37
38 Most participants wanted their health care and treatment to be organized in such a way
39 that it was possible to see the same physician at each consultation, and they appreciated small
40 units/departments. The participants appreciated the possibility of contacting the physicians
41 and nurses if needed, to have “an open door”. Some of those who had to alternate between
42 different physicians felt that they had to start from the beginning each time, which they found
43 exhausting.
44
45
46
47
48
49
50

51
52
53 *“I am an introverted person. I am not able to speak openly with everyone. When I meet a new*
54 *physician, I have to start from the beginning, and I don’t like it. And it’s OK to feel like this.*
55 *We’re all different” (patient 2, woman aged 73 years).*
56
57
58
59
60

1
2
3 In addition to the discomfiting feeling of having to deal with new physicians, some
4 participants reported that information was not forwarded between the different physicians,
5 resulting in misunderstandings. They felt insecure and that no one was in charge of their
6 medical care, for example, when experiencing changes in treatment at the same time as they
7 changed physicians/junior doctors. Further, some participants highlighted that a lack of co-
8 ordination in treatment and care imposed an extra burden, and emphasized that confidence
9 was inspired by better organization and by the professional knowledge and ability of nurses
10 and physicians to answer questions.
11
12
13
14
15
16
17
18
19
20
21

22 Discussion

23
24 To our knowledge, this is the first study to explore the thoughts of patients with colorectal
25 cancer undergoing palliative care about how information was communicated about their
26 disease, prognosis and life expectancy, from the first time that they were informed that their
27 disease was incurable to post-surgery palliative treatment.
28
29
30
31
32
33

34 Evident in our findings was the asymmetrical relationship in which the physicians held
35 the knowledge and expertise about the disease and the participants had to trust them. As
36 Løgstrup¹⁹ emphasizes, trust is something fundamental to our lives and implies that you
37 expose yourself to others and become vulnerable. Vulnerability implies that others are in
38 control and hold their fellow humans' lives in their hands. The responsibility of HCPs in such
39 asymmetrical relationships is especially important in palliative care. The participants wanted
40 information about their incurable cancer to be provided in a sensible and sensitive way, in a
41 setting that allowed enough time. However, according to many of our participants, the
42 communication in these meetings failed to give them sufficient help to deal with the
43 information and their vulnerability. Being the first to inform patients that they have an
44 incurable disease is difficult, and bearers of bad news may later be blamed despite their best
45 intentions to provide information in a sensitive manner. Furthermore, in surgical departments,
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 there is limited time allocated for surgeon–patient communication, and doctors in surgical
4 specialities are significantly more likely to be rated poorly than non-surgical specialists or
5
6 GPs when breaking bad news.¹⁸
7
8
9

10 Previous studies highlight that palliative treatment implies hope. Hope is an important
11 coping strategy in such patients,^{28 29} and has been described as essential for human life. The
12 realistic hope for most of our participants was that something could be done to relieve their
13 symptoms and potentially to postpone death, and to enable them to lead ordinary everyday
14 lives and have the possibility of spending time with family and friends. Therefore, the patients
15 emphasized the importance of HCPs including hope in their communications of disease,
16 prognosis and life expectancy throughout the disease trajectory. Studies have shown that there
17 is a fine balance between telling the truth and nurturing hope, and that there is a spectrum of
18 hope, from hope for a cure to hope for living as normally as possible.^{16 30} This aspect was
19 also identified in our study.
20
21
22
23
24
25
26
27
28
29
30
31
32

33 There was diversity in how detailed the participants wanted information about their
34 disease and likely future prospects to be. Previous work indicates that patients with incurable
35 cancer want truthful information about their disease, treatment and likely future prospects.³¹
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
841
842
843
844
845
846
847
848
849
850
851
852
853
854
855
856
857
858
859
860
861
862
863
864
865
866
867
868
869
870
871
872
873
874
875
876
877
878
879
880
881
882
883
884
885
886
887
888
889
890
891
892
893
894
895
896
897
898
899
900
901
902
903
904
905
906
907
908
909
910
911
912
913
914
915
916
917
918
919
920
921
922
923
924
925
926
927
928
929
930
931
932
933
934
935
936
937
938
939
940
941
942
943
944
945
946
947
948
949
950
951
952
953
954
955
956
957
958
959
960
961
962
963
964
965
966
967
968
969
970
971
972
973
974
975
976
977
978
979
980
981
982
983
984
985
986
987
988
989
990
991
992
993
994
995
996
997
998
999
1000

32 However, because of individual preferences, individually customized approaches would
seem desirable,^{33 34} and could be considered an important part of a patient’s life-world that
should be attended to in communication between patients and physicians or nurses. Although
all the participants in the present study were aware of the incurable nature of their disease, we
did not explore the accuracy of their prognostic awareness. However, in a systematic review
and meta-regression analysis, Chen et al.³⁵ identified that only half the cancer patients with
advanced disease accurately understood their prognosis.

In our study, the participants emphasized the importance of organizing all their
palliative treatment and care with well-qualified physician or nurse. They seemed to prefer

1
2
3 that physician or nurse communications included what Mishler²⁰ has characterized as the
4 “voice of medicine”, which mainly focuses on the symptoms and medical and technical
5
6 problems or aspects of the disease. But they also wanted physicians and nurses to initiate
7
8 communication focusing on the participants’ inner thoughts related to their illness, Mishler’s
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
20 “voice of the lifeworld”, which included asking more open-ended questions. Physicians and
nurses who do this are characterized as compassionate caregivers.³⁶

Implications for health care

It might be considered overly demanding to be the bearer of the bad news that a patient has an incurable disease. Some of our participants experienced the first information about their incurable disease as delayed, insufficient, given in an inappropriate way or at an inappropriate place. This indicates that there is a need for increased focus on communication by HCPs both during their university studies and in hospitals.⁸ Furthermore, it would be desirable for surgeons to have more time allocated to conveying information and communicating with patients.

Physicians and nurses have extensive responsibilities in how they communicate with patients who have an incurable disease, particularly because of the asymmetrical relationship between patients and HCPs. The HCPs have knowledge about how the disease will most likely progress and about common psychological responses. However, the patients’ inner thoughts and life-world are not necessarily known to the HCPs. The responsibility to invite or initiate communication about the patients’ inner thoughts is in the hands of the physicians and nurses. Furthermore, it is important to strive for a more symmetrical relationship between patients and HCPs,^{19 28} which will also increase the possibility of shared decision-making in treatment and care.

The participants preferred compassionate physicians and nurses. Being compassionate requires more than empathy; it requires knowledge, proactivity and interconnectedness.³⁶

1
2
3 Furthermore, to become a compassionate physician or nurse, training is required involving
4 observation, guidance and feedback about one's own practice.³⁶ HCPs also need to be aware
5 of how much information each patient prefers and discuss this with the patient. Previous
6 studies have shown that this awareness is associated with years of practice and confidence.^{8 10}
7
8 Treatment and care of patients undergoing palliative chemotherapy should be organized in
9 such a way that patients are able to see the same well-qualified physician and optionally also
10 the same nurses at each consultation. Furthermore, palliative health care should include
11 guidelines on how to treat the patients more smoothly, and allow enough time for
12 communication with this vulnerable patient group.
13
14

15 **Methodological considerations**

16
17 The strengths of the study are that the 20 participants provided us with rich data about their
18 experiences, feelings and reflections upon the information and communication by HCPs about
19 their disease and life expectancy during their disease trajectory. Qualitative content analysis
20 aims to stay close to the data and texts to elucidate the findings, although our pre-
21 understanding of the issues as researchers might also have influenced the analysis of the data.
22
23 Another strength of our study is that it included patients with one type of cancer who were in
24 the palliative phase. Colorectal cancer is the second most common cancer diagnosed in
25 women worldwide, and the third most common cancer diagnosed in men;^{21 22} thus, the
26 knowledge gained in this study could be applied to this large group of patients. However, it is
27 also possible that studying just one patient group might limit the variation in findings that
28 may have been identified by including more heterogeneous groups. We have limited
29 systematic information about the participants' socio-demographic variables, common
30 behaviour and coping mechanisms that might have influenced their experiences and
31 preferences. However, based on the few characteristics we identified during the interviews,
32 the variations in socio-demographic factors such as gender, age, and marital status seem to be
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 similar to those of patients with colorectal cancer reported by Jemal et al.²¹ Although our
4
5 findings are not generalizable to patients with other cancer diagnoses, they may be
6
7 transferable to hospitals with a similar organization of surgery and post-surgery palliative
8
9 treatments.
10

11 12 13 **Conclusions**

14
15
16 The findings of this study provide a deeper understanding about how patients with incurable
17
18 colorectal cancer undergoing palliative treatment experience and reflect upon HCP–patient
19
20 communication about disease and life expectancy from before surgery through to post-surgery
21
22 chemotherapy. The process of receiving the first information that they had an incurable
23
24 disease was generally experienced as inadequate, while post-surgery palliative chemotherapy,
25
26 physicians and nurses offered hope. The participants preferred customized information about
27
28 treatment and likely future prospects, and physicians and nurses who used a holistic approach
29
30 focusing on their life-world with compassion. To become a sensitive, holistic and
31
32 compassionate physician or nurse requires knowledge and confidence, and to achieve this,
33
34 training and guidance are needed.
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Authors' contributions

GR and IV were responsible for the study design. GR was responsible for the patient interviews and data collection. GR, US and IV contributed to a critical appraisal of the analysis, manuscript preparation, and read and approved the final version of the manuscript.

Competing interests: The authors declare that they have no competing interests.

Acknowledgements: We thank the Department of Clinical Research at Sorlandet Hospital and the Faculty of Health and Sport Science, University of Agder for funding the study. Gudrun Rohde was a visiting researcher, as an Affiliate Academic, in the Marie Curie Palliative Care Research Department, University College London, January–June 2017 while writing most of the paper. We wish to thank the three patients who helped us with pilot interviews during the design of the study, as well as all the patients who participated.

Funding: No further funding to disclose.

Data sharing statement: Owing to the sensitive nature of the information (in Norwegian) and appropriate medical ethics, access to the raw data is difficult.

References

1. McRee AJ, Goldberg RM. Optimal management of metastatic colorectal cancer: current status. *Drugs* 2011;71(7):869-84.
2. Cameron J, Waterworth S. Patients' experiences of ongoing palliative chemotherapy for metastatic colorectal cancer: a qualitative study. *International journal of palliative nursing* 2014;20(5):218-24. [published Online First: 2014/05/24]
3. Cameron MG, Kersten C, Guren MG, et al. Palliative pelvic radiotherapy of symptomatic incurable prostate cancer - a systematic review. *Radiother Oncol* 2014;110(1):55-60. doi: 10.1016/j.radonc.2013.08.008 [published Online First: 2013/09/21]
4. Cameron MG, Kersten C, Vistad I, et al. Palliative pelvic radiotherapy for symptomatic rectal cancer - a prospective multicenter study. *Acta Oncol* 2016;55(12):1400-07. doi: 10.1080/0284186x.2016.1191666 [published Online First: 2016/06/23]
5. Hancock K, Clayton JM, Parker SM, et al. Truth-telling in discussing prognosis in advanced life-limiting illnesses: a systematic review. *Palliat Med* 2007;21(6):507-17. doi: 10.1177/0269216307080823 [published Online First: 2007/09/12]

6. Hagerty RG, Butow PN, Ellis PM, et al. Communicating prognosis in cancer care: a systematic review of the literature. *Ann Oncol* 2005;16(7):1005-53. doi: 10.1093/annonc/mdi211 [published Online First: 2005/06/09]
7. Chou WS, Hamel LM, Thai CL, et al. Discussing prognosis and treatment goals with patients with advanced cancer: A qualitative analysis of oncologists' language. *Health expectations : an international journal of public participation in health care and health policy* 2017;20(5):1073-80. doi: 10.1111/hex.12549 [published Online First: 2017/03/07]
8. Suwanabol PA, Kanters AE, Reichstein AC, et al. Characterizing the Role of U.S. Surgeons in the Provision of Palliative Care: A Systematic Review and Mixed-Methods Meta-Synthesis. *J Pain Symptom Manage* 2018;55(4):1196-215.e5. doi: 10.1016/j.jpainsymman.2017.11.031 [published Online First: 2017/12/10]
9. Dillon BR, Healy MA, Lee CW, et al. Surgeon Perspectives Regarding Death and Dying. *Journal of palliative medicine* 2018 doi: 10.1089/jpm.2018.0197 [published Online First: 2018/11/21]
10. Rogg L, Aasland OG, Graugaard PK, et al. Direct communication, the unquestionable ideal? Oncologists' accounts of communication of bleak prognoses. *Psychooncology* 2010;19(11):1221-28.
11. Murray CD, McDonald C, Atkin H. The communication experiences of patients with palliative care needs: A systematic review and meta-synthesis of qualitative findings. *Palliative & supportive care* 2015;13(2):369-83. doi: 10.1017/s1478951514000455 [published Online First: 2014/05/03]
12. Martinsson L, Axelsson B, Melin-Johansson C. Patients' perception of information from physicians during palliative chemotherapy: a qualitative study. *Psychooncology* 2016;14(5):495-502. doi: 10.1017/S1478951515001200
13. Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. *BMJ* 2004;328(7452):1343. doi: 10.1136/bmj.38103.423576.55 [published Online First: 2004/05/21]
14. Butow PN, Dowsett S, Hagerty R, et al. Communicating prognosis to patients with metastatic disease: what do they really want to know? *Support Care Cancer* 2002;10(2):161-8. doi: 10.1007/s005200100290 [published Online First: 2002/02/28]
15. Clarke MG, Kennedy KP, MacDonagh RP. Discussing life expectancy with surgical patients: do patients want to know and how should this information be delivered? *BMC medical informatics and decision making* 2008;8:24. doi: 10.1186/1472-6947-8-24 [published Online First: 2008/06/17]
16. Clayton JM, Butow PN, Arnold RM, et al. Fostering coping and nurturing hope when discussing the future with terminally ill cancer patients and their caregivers. *Cancer* 2005;103(9):1965-75. doi: 10.1002/cncr.21011 [published Online First: 2005/03/25]
17. Stajduhar KI, Thorne SE, McGuinness L, et al. Patient perceptions of helpful communication in the context of advanced cancer. *J Clin Nurs* 2010;19(13-14):2039-47. doi: 10.1111/j.1365-2702.2009.03158.x [published Online First: 2010/10/06]
18. Barnett MM. Effect of breaking bad news on patients' perceptions of doctors. *Journal of the Royal Society of Medicine* 2002;95(7):343-7. [published Online First: 2002/07/02]
19. Løgstrup KE. The ethical demand. Notre Dame, Ill: University of Notre Dame Press 1997.
20. G ME. The Discourse of Medicine - Dialectics of Medical Interviews. New Jersey: Ablex Publishing Corporation, Norwood, New Jersey 1984.
21. Jemal A, Center MM, DeSantis C, et al. Global patterns of cancer incidence and mortality rates and trends. *Cancer Epidemiol Biomarkers Prev* 2010;19(8):1893-907. doi: 10.1158/1055-9965.epi-10-0437 [published Online First: 2010/07/22]

22. Torre LA, Bray F, Siegel RL, et al. Global cancer statistics, 2012. *CA Cancer J Clin* 2015;65(2):87-108. doi: 10.3322/caac.21262 [published Online First: 2015/02/06]
23. Crabtree BF, Miller WL. Doing qualitative research. Thousand Oaks, Calif.: Sage 1999.
24. Rohde G, Kersten C, Vistad I, et al. Spiritual Well-being in Patients With Metastatic Colorectal Cancer Receiving Noncurative Chemotherapy: A Qualitative Study. *Cancer Nurs* 2016 doi: 10.1097/ncc.0000000000000385 [published Online First: 2016/04/22]
25. Polit DF. Essentials of nursing research: methods, appraisal, and utilization. Philadelphia: Lippincott Williams & Wilkins 2006.
26. Beauchamp TL, Childress JF. Principles of biomedical ethics. 7th ed. ed. New York: Oxford University Press 2013.
27. WMA Declaration of Helsinki. Ethical Principles for Medical Research Involving Human Subjects 2013 [Available from: <http://www.wma.net/en/30publications/10policies/b3/>]
28. Hegarty M. The Dynamic of Hope: Hoping in the Face of Death. *Progress in Palliative Care* 2001;9(2):42-46. doi: 10.1080/09699260.2001.11746903
29. Rustoen T. Hope and quality of life, two central issues for cancer patients: a theoretical analysis. *Cancer Nurs* 1995;18(5):355-61. [published Online First: 1995/10/01]
30. Clayton JM, Butow PN, Arnold RM, et al. Discussing life expectancy with terminally ill cancer patients and their carers: a qualitative study. *Support Care Cancer* 2005;13(9):733-42. doi: 10.1007/s00520-005-0789-4 [published Online First: 2005/03/12]
31. Miccinesi G, Bianchi E, Brunelli C, et al. End-of-life preferences in advanced cancer patients willing to discuss issues surrounding their terminal condition. *Eur J Cancer Care (Engl)* 2012;21(5):623-33. doi: 10.1111/j.1365-2354.2012.01347.x [published Online First: 2012/04/24]
32. Hagerty RG, Butow PN, Ellis PA, et al. Cancer patient preferences for communication of prognosis in the metastatic setting. *J Clin Oncol* 2004;22(9):1721-30. doi: 10.1200/jco.2004.04.095 [published Online First: 2004/05/01]
33. Mackenzie LJ, Carey ML, Paul CL, et al. Do we get it right? Radiation oncology outpatients' perceptions of the patient centredness of life expectancy disclosure. *Psychooncology* 2013;22(12):2720-8. doi: 10.1002/pon.3337 [published Online First: 2013/06/27]
34. Walczak A, Butow PN, Davidson PM, et al. Patient perspectives regarding communication about prognosis and end-of-life issues: how can it be optimised? *Patient Educ Couns* 2013;90(3):307-14. doi: 10.1016/j.pec.2011.08.009 [published Online First: 2011/09/17]
35. Chen CH, Kuo SC, Tang ST. Current status of accurate prognostic awareness in advanced/terminally ill cancer patients: Systematic review and meta-regression analysis. *Palliat Med* 2017;31(5):406-18. doi: 10.1177/0269216316663976 [published Online First: 2016/08/06]
36. Larkin PJ. Compassion - The Essence of Palliative and End-of-life Care. First ed. New York: Oxford University Press 2016.

Table 1: Characteristics of patients receiving non-curative chemotherapy.

	First-line (<i>n</i> = 12)	Second-line (<i>n</i> = 8)
Women	5	3
Men	7	5
Mean age (range), years	63 (34–75)	69 (64–75)
Marital status:		
Married/cohabiting	10	8
Single	1	
Widow/widower	1	
Chemotherapy used:		
FOLFIRI/bevacizumab	10	
FLOX (5-fluorouracil, folinic acid, oxaliplatin)	1	8
Capecitabine plus oxaliplatin (XELOX)	1	

All patients received 5-fluorouracil-based combination chemotherapy with irinotecan or oxaliplatin, +/- bevacizumab.

Table 1

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	G Rohde (All interviews), p 7
2.	Credentials	PhD and professors, p 1
3.	Occupation	Professors, p 1
4.	Gender	All female, p 7
5.	Experience and training	All were trained researchers, p 7
Relationship with participants		
6.	Relationship established	No relationship before the interviews, p 7
7.	Participant knowledge of the interviewer	The participants did not know the interviewer, p 7
8.	Interviewer characteristics	Nurse and professor and had interests for the topic, p 7
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	Content analysis, p7
Participant selection		
10.	Sampling	The patients physicians asked if the researcher could contact them for inclusion, p 6
11.	Method of approach	Face-to-face, p 7
12.	Sample size	Twenty patients (Twelve men and eight women), p 6

No	Item	Guide questions/description
13.	Non-participation	We have limited information about this, p 6
Setting		
14.	Setting of data collection	Out-patient clinic and patients home (one patient), p 7
15.	Presence of non-participants	Non, p 6
16.	Description of sample	Patients with metastatic colorectal cancer receiving non-curative chemotherapy, p 6
Data collection		
17.	Interview guide	The interview guide was made by the researchers, p 7 and 8
18.	Repeat interviews	No repeated interviews were performed, p 7
19.	Audio/visual recording	Audio recording was used to collect the data, p 7
20.	Field notes	Field notes were made after the interviews, not stated in the manuscript
21.	Duration	50-100 minutes, p 7
22.	Data saturation	Data saturation was discussed and reached, p 7
23.	Transcripts returned	The transcripts were not returned to participants for comments, not stated in the manuscript
Domain 3: analysis and findingsz		
Data analysis		
24.	Number of data coders	one, p 8
25.	Description of the coding tree	The authors provided a description of the coding, p 8
26.	Derivation of themes	The themes were derived from the data, p 8

No	Item	Guide questions/description
27.	Software	none
28.	Participant checking	The participants did not provide feedback on the findings, not written in the manuscript
Reporting		
29.	Quotations presented	The quotations presented illustrate the themes / findings, p 9 - 14
30.	Data and findings consistent	There was consistency between the data presented and the findings p 8 - 14
31.	Clarity of major themes	Major themes were clearly presented in the findings, p 8
32.	Clarity of minor themes	No

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60