

Patient-Clinician Communication: ASCO Guideline Update

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ABSTRACT

ASCO Guidelines provide recommendations with comprehensive review and analyses of the relevant literature for each recommendation, following the guideline development process as outlined in the [ASCO Guidelines Methodology Manual](#). ASCO Guidelines follow the [ASCO Conflict of Interest Policy for Clinical Practice Guidelines](#).

Clinical Practice Guidelines and other guidance (“Guidance”) provided by ASCO is not a comprehensive or definitive guide to treatment options. It is intended for voluntary use by clinicians and should be used in conjunction with independent professional judgment. Guidance may not be applicable to all patients, interventions, diseases or stages of diseases. Guidance is based on review and analysis of relevant literature and is not intended as a statement of the standard of care. ASCO does not endorse third-party drugs, devices, services, or therapies and assumes no responsibility for any harm arising from or related to the use of this information. See complete disclaimer in [Appendix 1](#) and [Appendix 2](#) (online only) for more.

PURPOSE To provide guidance to oncology clinicians on using effective communication to optimize the patient-clinician relationship, patient and clinician well-being, and caregiver well-being.

METHODS ASCO convened a multidisciplinary panel of medical oncologists, hematologists, nurses, hospice and palliative medicine clinicians, and communication skills and advocacy experts to develop recommendations. Guideline development involved a systematic review of the literature and a formal consensus process. The systematic review encompassed systematic reviews and randomized controlled trials (RCTs) published from October 1, 2016, through January 16, 2025.

RESULTS The systematic review identified 73 publications (54 systematic reviews and 19 RCTs). Included studies varied with respect to setting and the interventions and outcomes evaluated. Recommendations were developed using a formal consensus process. Draft recommendations underwent two rounds of consensus voting before being finalized.

RECOMMENDATIONS Recommendations address core communication skills and tasks that apply across the continuum of cancer care, as well as specific topics such as discussion of goals of care and prognosis, treatment selection, end-of-life care, facilitating involvement of the patient’s support network, and clinician training in communication skills. In addition, new topics addressed by this update include telehealth, interprofessional communication, and boundary setting. Recommendations are accompanied by suggested strategies for implementation. Full implementation of communication best practices will require that health systems provide adequate time, training, and support for clinicians. Additional information is available at <https://ascopubs.org/topics/asco-guidelines/supportive-care-quality-life>.

ACCOMPANYING CONTENT

Appendix
 Data Supplement

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INTRODUCTION

Effective health care communication has been associated with improvements in objective and subjective patient health

outcomes, including blood pressure control, hemoglobin A1C control in diabetes, medication use, and patient satisfaction.^{1–11} Communication in oncology care presents numerous challenges, however. Clinicians often share

TARGET POPULATION AND AUDIENCE

Target Population

Adults with cancer and members of their support network.

Target Audience

Clinicians who care for adults with cancer.

devastating news with patients and families. Cancers are frightening diseases, and patients may react to diagnostic and treatment information with fear, grief, denial, or anger—strong emotions that may elicit discomfort in clinicians. Clinicians can support patients and help them cope by building rapport and trust, checking on their well-being, conveying information clearly and accurately, communicating empathy about health and other concerns, working with patients to ensure shared decision making regarding treatment decisions as well as decisions about documentation, and addressing concerns of patients and members of their support networks within the time constraints of clinical practice.

Cancers represent diverse diseases with complex pathogenesis and treatments, which are challenging to describe and understand. Moreover, many clinicians have received scant training on delivering information about complex health issues so that patients can comprehend, retain, and use the information for appropriate action.

Natural interpersonal skills are insufficient to communicate effectively in health care; specific health care communication skills and practices are needed. This document provides guidance to oncology clinicians on communicating effectively to optimize patient care, the patient-clinician relationship, and the well-being of clinicians, patients, and members of patients' support networks. This guideline also touches on key aspects of effective communication skills training. Well-designed training programs can improve clinicians' communication skills and patients' experiences.¹²⁻¹⁶ Challenging conversations are akin to complex interventional procedures. They both require careful planning, execution, and use of well-developed strategies to facilitate optimal outcomes.

This document serves as an update to ASCO's first guideline on patient communication, published in 2017,¹⁷ and expands the scope to include three new topics: communication during telehealth encounters, interprofessional communication, and boundary setting during clinical encounters.

GUIDELINE QUESTIONS

This update addresses 11 clinical questions: what communication skills and practices apply to (1) every visit, across the continuum of cancer care? (2) telehealth interactions? (3)

cross-disciplinary communication? (4) discussion of prognosis and goals of care? (5) treatment selection, including discussion of clinical trials? (6) end-of-life discussions? (7) facilitating involvement of the patient's support network? (8) overcoming barriers to communication, such as language differences and differences in understanding health information? (9) discussions of cost of care and financial toxicity? (10) mitigating stigma? and (11) setting boundaries with patients? It also addresses one educational question: what are the most effective ways for clinicians to learn to enhance their communication skills?

METHODS

Guideline Development Process

This guideline was developed by a multidisciplinary Expert Panel, which included a patient representative and an ASCO guidelines staff member with health research methodology expertise (Appendix [Table A1](#), online only).

Recommendation development was based on a systematic review of the literature, clinical and lived experience, and a formal consensus process. The updated systematic review involved searches of PubMed and the Cochrane Library for the period from October 1, 2016, through January 16, 2025. Searches were limited to systematic reviews and randomized controlled trials (RCTs). Articles were selected for inclusion based on the following:

- Population: Adults with cancer
- Interventions: In-person or telehealth communication between clinicians and adults with cancer; receipt of communication skills training by clinicians
- Comparisons: Usual care, a different communication strategy, or nonreceipt of communication skills training
- Outcomes: Patient, caregiver, and clinician satisfaction; quality of information conveyed by clinician; patient and caregiver understanding and retention of information; improved rapport; improved health and well-being of patients and clinicians

Articles were excluded from the systematic review if they were (1) meeting abstracts not subsequently published in peer-reviewed journals; (2) editorials, commentaries, letters, news articles, case reports, narrative reviews; (3) published in a language other than English; (4) focused on cancer prevention, risk assessment, or screening; or (5) focused on decision aids.

Because of the limited evidence available for many of the clinical questions, recommendations were developed using the ASCO modified Delphi formal consensus methodology.¹⁸ This process involved the drafting of recommendations and implementation strategies by subgroups of the Expert Panel. The Expert Panel was then supplemented by additional experts who were recruited to rate their agreement with the recommendations and strategies (Appendix [Table A2](#)). The entire membership of experts is

TABLE 1. Core Communication Skills With Patients and Their Support Networks

Recommendation and Level of Agreement	Strategies
1.1. Prior to each conversation, clinicians should review the patient's medical information, establish goals for the conversation, and anticipate the needs and responses of the patient and members of their support network. 96%	a. Arrange for an appropriate location for the conversation and enough time to give the information and answer questions. b. Have all the information necessary to conduct an effective encounter. c. Know who should be present for the conversation. d. Prepare 1-3 goals or take-home messages for the conversation. e. Anticipate and prepare to assess the emotional responses of the patient and members of their support network. f. Anticipate questions that might be asked. g. Inquire about the patient's learning style, preferred method to receive information, and how they make decisions (eg, in the moment, need time to reflect). h. Inquire if members of the patient's support network are not able to attend meetings in person and ask whether they are informed about patient-clinician conversations. Consider offering a teleconference for people who are important to the patient but cannot be physically present (see Clinical Question 2). i. Explore whether financial constraints may create barriers to care (see Clinical Question 9).
1.2. After inquiring what the patient and members of the patient's support network wish to address and explaining what the clinician wishes to address, clinicians should collaboratively set an agenda with the patient and key members of their support network. 92%	a. Use open-ended questions to encourage the patient to share what is important to them. For example, "What would you like to make sure we talk about today? I want to make sure I cover the issues important to you." b. May use previsit patient-reported outcomes, previsit coaching interventions, and question prompt lists.
1.3. During patient visits, clinicians should engage in behaviors that actively foster trust, confidence in the clinician, and collaboration. 96%	a. Introduce oneself and one's role in the patient's care and, if the patient is accompanied by others, inquire about their relationship to the patient. b. Sit down. c. Be friendly and professional. d. Engage in reflective listening: refrain from interrupting the patient and summarize the key elements of what you are hearing to ensure accurate understanding. e. Make eye contact. f. Maintain a calm demeanor. g. Get to know the patient as a person, finding out about what their life was like prior to their cancer diagnosis, and how cancer has changed their life. h. Explore the patient's understanding of the disease. i. Inquire about how the patient and members of their support network are coping and feeling. j. Be honest, genuine, and respectful.
1.4. Clinicians should provide information that is timely and oriented to the patient's concerns and preferences for information. After providing information, clinicians should check for patient understanding and document important discussions in the health record. 96%	a. Avoid unnecessary delays in providing information. b. Communicate with consultants and others involved in the patient's care so that the patient receives coherent recommendations and information. Different clinicians may legitimately disagree with each other, but differences of opinion should be explained, and clinicians should actively help patients process and interpret differing recommendations. c. Consider whether the information is appropriate to provide by phone, mail, or email, or if an in-person meeting is needed. d. Orient the patient, if necessary, to make sure they understand what will be discussed and why (eg, "I have the results of the CT scans you had done yesterday, and I wanted to go over the results with you if that's ok.>"). e. Orient yourself to the patient's understanding and concerns: Ask the patient what they know and what they want to know (eg, "Please tell me what you understand, or what you have been told, about why you are in the hospital and what we are doing to help you get better." "What have the other clinicians told you about your cancer?" "What are the things that you want to make sure we discuss today?"). f. Use simple language tailored to the patient's educational level. A patient may be intelligent and well educated but still have low health care literacy. g. Avoid jargon (eg, "response rate" or "positive test result") and explain in lay language when you must use medical terminology. h. Provide information that is relevant to what the patient wants to know and to the patient's goals. i. Avoid information overload by providing information in small chunks, stopping frequently, and checking for comprehension. j. Check for understanding by using a "teach back" or "talk back" method, with a statement such as, "In your own words, what does this mean to you?" or "What will you tell your family or other members of your support network about what we discussed?" k. Assure the patient that you are available to answer questions in the future and clarify how best to communicate after the visit.

(continued on following page)

TABLE 1. Core Communication Skills With Patients and Their Support Networks (continued)

Recommendation and Level of Agreement	Strategies
1.5. When a patient displays emotion through verbal or nonverbal behavior, clinicians should respond empathically. 92%	a. Observe, acknowledge, and name the emotions (eg, "You seem sad today," "This has been a very tough 6 months for you," "I know you had a bad time when you were on chemotherapy previously and that you've been worried about starting it again," "It's stressful coming in for these scans and having to worry about what the results will be."). b. Ask the patient what they are most concerned about and explore what's behind strong emotions (eg, "Tell me what you are worried about." "What has been the hardest part of all this for you?" "Help me understand what you are feeling right now."). c. Use partnership and supporting statements (eg, "I want to make sure we do everything we can to get you the best outcome;" "I know this has been a rough time and I want to do what I can to help you feel better," "I'm distressed to hear that you've been suffering so much, and I'm hoping we can work together to improve your quality of life;" "I would like to provide information that would be helpful to you."). d. Be cautious about providing information when a patient is emotional. When in a strongly emotional state, people often have difficulty absorbing and processing information.

Abbreviation: CT, computed tomography.

referred to as the Consensus Panel. Each recommendation required at least 75% agreement among the Consensus Panel respondents to be accepted.

Five full panel meetings were held, and members were asked to provide ongoing input on the updated guideline development protocol, quality and assessment of the evidence, generation of recommendations, draft content, as well as review and approve drafts during the entire development of the guideline. ASCO staff met routinely with the Expert Panel co-chairs and corresponded with the panel

via e-mail to coordinate the process to completion. Ratings for strength of the recommendation and evidence quality are based on the GRADE quality assessment and recommendations development process (Appendix Table A3).^{19,20} All funding for the administration of the project was provided by ASCO.

Guideline Review and Approval

After the panel approved the recommendations, additional edits were recommended by ASCO staff and incorporated

TABLE 2. Telehealth Communication

Recommendation and Level of Agreement	Strategies
2.1. Clinicians may use telehealth modalities to replace or supplement traditional in-person communication and care in many instances. Telehealth may be delivered via telephone, video, text messaging, mobile apps, patient portals, and wearable monitors. In addition, secure messaging can complement traditional forms of communication. 96%	a. Assess the patient's access to technology and the internet. b. Complex conversations can generally be conducted more effectively in person, but sometimes there are sound reasons for doing them remotely. If using telehealth for complex conversations, such as breaking bad news, build a relationship with the patient first and sequence the information-sharing process carefully to minimize surprise. c. Ensure the telehealth modality is appropriate for purpose of communication (eg, video call for sensitive conversations, secure messaging for simple clarification or instruction).
2.2. Ensure telehealth communication safeguards are in place to protect confidential sharing of health information. 96%	a. Ask the patient and members of their support network explicitly about who is present for the telehealth conversation, what their relationship to the patient is, and whether there are other people who may remain unseen or unheard and may overhear the conversation. b. Secure the conversation through available privacy software. c. Do not video- or audio-record information without express consent. Conversely, ask the patient and supporting members if they are recording the conversation.
2.3. Adapt exemplary communication skills from in-person meetings (see Clinical Question 1) to telehealth settings. 100%	a. Use active listening and empathic reflection techniques. When compared with in-person settings, lower-context settings such as telehealth often require increased use of explicit empathic statements. b. When feasible, schedule video visits rather than audio-only visits. c. In video visits, ideally place the camera on the screen so that your gaze is directed toward the patient. Apologize and acknowledge when it is necessary to look away from the patient. Optimize lighting as much as possible, reduce ambient noise, ensure you are speaking at a volume that can be heard, and speak slowly enough that listeners can follow.
2.4. Given the increased volume of telehealth encounters, organizations must construct and maintain systems to support and enhance clinician well-being. 97%	a. Assign members of the health care team to address patient concerns promptly; train team members in triage techniques to ensure that urgent or emergent health problems are addressed with appropriate timeliness and in an appropriate setting. b. Advocate for reasonable methods of compensation, financial or otherwise, for time spent on telehealth encounters.

NOTE. See also: Telehealth in Oncology: ASCO Standards and Practice Recommendations.¹¹⁴

TABLE 3. Interprofessional Communication

Recommendation and Level of Agreement	Strategies
3.1. Health care teams should establish a structure and system to support high-quality communication across the different members of the care team. 92%	a. Inpatient teams may schedule daily huddles where representatives from as many disciplines or professions involved in the patient's care are present as possible. b. For outpatient teams, schedule times or adopt formalized processes for reviewing shared patients. c. Establish accountability for timely documentation so that the health record accurately reflects the current plan. d. Establish an agreed-upon and reliable mechanism for timely communication among members of the care team about urgent matters related to the patient's care.
3.2. Implement strategies that foster a sense of belonging among team members and ensure that all team members are treated with respect. 97%	a. When rounding or discussing a patient in interprofessional settings, invite input from all disciplines or professions involved in the patient's care. b. Listen to other team members without interrupting. c. Establish ground rules for how the team communicates and facilitates rounds and meetings. d. Express appreciation for each team member's contributions to the team and to patient care. e. Learn each other's names, including how to pronounce them, and how team members would like to be addressed in third person. f. Use language that supports the importance and dignity of each person in every role on the health care team. g. When problems arise, health care teams should focus on determining the root cause and any structural, systems, or institutional issues that contributed to the problem or allowed it to happen. Avoid blame culture. h. Focus on preventing adverse events and establishing accountability. i. Team members who are involved with an error should be supported and treated with empathy rather than retribution.
3.3. After a patient death or another emotionally upsetting event occurs, health care teams should have a process for debriefing the event. 85%	a. Acknowledge the event when the team is together and give team members an opportunity to express their feelings about it. These can be separate meetings especially for this purpose or included in a huddle. b. Debrief in a private area where team members can share their feelings without being overheard by outsiders. c. Refer team members to appropriate resources if they want or need additional support.

prior to public comment. The draft recommendations were then released to the public for open comment from May 23, 2025, through June 6, 2025. Response categories of "Agree as written," "Agree with suggested modifications," and "Disagree. See comments" were captured for every proposed recommendation. Eight responses were received, and Expert Panel members reviewed comments and incorporated several revisions prior to finalizing the guideline.

All changes were incorporated into the final manuscript prior to ASCO Evidence Based Medicine Committee (EBMC) review and approval. All ASCO guidelines are ultimately reviewed and approved by the Expert Panel and the ASCO EBMC before submission to the *Journal of Clinical Oncology* for editorial review and consideration for publication.

Guideline Updating

The ASCO Expert Panel and guidelines staff will work with co-chairs to keep abreast of any literature that would require substantive updates to the guideline. Based on formal review of the emerging literature, ASCO will determine the need to update. The ASCO Guidelines Methodology Manual (available at www.asco.org/guideline-methodology) provides additional information about the guideline update process. This is the most recent information as of the publication date.

RESULTS

Characteristics of Studies Identified in the Updated Literature Search

The literature search identified 1,892 publications. Of the 164 publications accepted based on title and abstract review, 73

were eligible based on full-text review: 54 systematic reviews^{21-45,46-60,61-74} and 19 RCTs.⁷⁵⁻⁹³ A listing of publications by Clinical Question is provided in the Data Supplement (online only). Clinical Question 11 (boundary setting by clinicians) had no eligible studies identified by the systematic review. The body of evidence was characterized by substantial heterogeneity in the populations, interventions, and outcomes that were evaluated. Given this variability, the overall body of evidence for any given outcome was rated as low. However, although evidence for specific interventions in specific circumstances remains limited in the oncology literature, the weight of the evidence in the broader health care literature supports that the content or perceived quality of communication with clinicians matters to patients and members of their support network.²⁷

For core communication skills, systematic reviews have explored both beneficial and detrimental approaches to communication. Communication that conveys empathy, support, and respect for the patient and their wishes can enhance the patient-clinician relationship and patient well-being.^{29,31,40} By contrast, communication that is not tailored to the needs of the patient, or that leaves the patient feeling unseen, unheard, or unsupported, may cause the patient to experience distress or other negative emotions.^{27,40}

Coordinated care across disciplines requires timely communication and well-defined and agreed-upon roles for cancer specialists and primary care clinicians. Tools and strategies for overcoming barriers to interprofessional communication continue to be evaluated.^{41,44,73}

Systematic reviews of goals of care and prognostic discussions have focused primarily on patients with advanced

TABLE 4. Communication About Goals of Care and Prognosis

Recommendation and Level of Agreement	Strategies
4.1. Clinicians should provide diagnostic and prognostic information that is tailored to the patient's needs and that provides hope and reassurance without misleading the patient. 100%	a. When discussing the patient's disease status and treatment history, assess the patient's understanding of their disease status, prognosis, and the effects of any treatments to date; their goals of care and treatment preferences; and how their goals of care relate to life goals, activities of daily living, and quality of life. b. Assess the patient's emotional state and readiness to process the information being shared. Determine whether the patient is prepared for explicit information, is ambivalent, or does not want information. If the patient is ambivalent, discuss the pros and cons of knowing. If the patient does not want to know, negotiate (with the patient's permission) a future discussion with members of the patient's support network. c. Determine if family members or other members of the patient's support network are involved, in agreement, and supportive. d. An example of providing hope might be assuring the patient that as their clinician, you will do everything you can to help them get the best possible outcome. Communication behaviors that facilitate hope include reframing ("Is there something in particular that you are hoping for now?") and nonabandonment ("I will do everything I can to support you."). e. Acknowledge and respect cultural differences in communication preferences, including how diagnostic and prognostic information is received and processed. f. Support shared decision making by presenting options and encouraging the patient's input.
4.2. Clinicians should reassess a patient's goals, priorities, and desire for information whenever a significant change in the patient's care is being considered. 92%	a. Attend to events that could warrant such a discussion, which include initial diagnosis, relapse, or progression, complications from treatment or the underlying disease, change in performance status, change in treatment approach, change in goals of care, and at the request of the patient or their support network. b. To establish a starting point for the conversation, ask the patient to explain what they understand about their illness, including the status of their disease and the treatment plan. c. After providing the patient with test results or other updates regarding their medical condition, consider asking, "Would you like to talk about what this means?"
4.3. Clinicians should provide information in simple and direct terms. 96%	a. Use balanced framing (eg, chance of a cure and chance of a relapse, or best/worst/most likely outcome). b. Provide information in multiple formats (verbally—words, numbers, ranges; or visually—diagrams, figures). c. Provide information in "chunks" (small discrete units) and check regularly for understanding. d. Use patient-centered language: say "the treatment has failed to help the patient" rather than "the patient has failed the treatment;" and "the treatment (or clinical trial) is not appropriate for this patient" rather than "the patient is not eligible for the treatment (or clinical trial)."
4.4. When providing bad news, clinicians should take additional steps to address the needs and responses of the patient. 100%	a. Ensure that the timing and setting are as appropriate and private as possible. b. Express solidarity (eg, "I wish I had better news."). c. State the bad news clearly and succinctly in plain, nontechnical language (eg, "Your cancer has spread to your liver."). d. Pause after delivering the bad news for the patient to absorb what has been said ("supportive silence"). e. Wait for the patient to respond before saying anything more. If the patient says nothing, clinicians can ask questions, such as "What's going through your mind?" or respond empathically (eg, "You look like you may be feeling overwhelmed."). f. Assess and respond empathically to patients' emotions. g. Avoid trying to reduce patient distress by minimizing the bad news or changing the subject. h. Titrate the amount of information to the patient's emotional state. i. Encourage patients to ask questions ("What questions do you have?") and use silence to create space for patients to express their concerns. j. Discuss the meaning of the findings and next steps before ending the conversation. k. Affirm commitment to supporting the patient (eg, "It's my job to help you get the best care possible," or "I'll continue to take care of you whatever happens.") and, if appropriate, help the patient find additional sources of support (eg, family, friends, religious community, support groups, therapist, or social worker).
4.5. When appropriate, discuss with the patient the roles and availability of palliative care. 100%	a. Ensure that the patient and their support network understand that referral to palliative medicine is not abandonment on your part and that the primary oncologic care will continue. b. Ensure that the patient and their support network understand the distinction between palliative medicine and hospice care.

cancer.^{22,23,37,38,43,51,52,70} Reviews highlight the importance of individualizing the discussions²² and considering their timing.²³ Variability in the content of these discussions³⁸ and persistence of inaccurate prognostic understanding among patients^{37,43,51} remain challenges. Treatment discussions also require individualized approaches, with the added challenge of how best to frame and present information about risks and benefits, and how to achieve shared decisions.^{25,33,53,65}

Telehealth can provide patients with convenient options for communicating with clinicians, but research into how and when to use telehealth continues to evolve. A systematic review of conveying bad news via telehealth, for example,

suggests that it does not increase patient distress relative to in-person communication but acknowledges the limited available evidence.³⁰ Research is also exploring how best to engage with patients via telehealth, and for what uses it is most effective.^{36,56}

Relatively few studies have addressed communication with members of the patient's support network. Strategies to address their information needs and well-being may provide important benefits.^{61,86,89}

Language and cultural differences between patients and clinicians may require additional skills or knowledge in order to meet patient needs.^{24,26,35,48,54,59,64} In the case of language

TABLE 5. Communication About Treatment Options

Recommendation and Level of Agreement	Strategies
5.1. Prior to discussing specific treatment options with the patient, forecast the discussion by setting a shared agenda of the topics that will be covered. Start by assessing the patient's current understanding of the disease status and treatment options; review symptom stress and changes in disease status and options; contextualize and adapt to the patient's goals and values. 96%	a. Determine whom the patient wants involved in conversations about their medical care or, for patients without decision-making capacity, who the surrogate decision maker(s) is (are). b. Revisit any previous conversations regarding the patient's values, goals of care, and treatment preferences. c. Ask whether and how these values and preferences have changed (eg, "In the past you expressed a desire to continue cancer treatment, and you have said that this last round of therapy has been hard on you. What are your current thoughts on treatment?"). d. Include the patient's support network when possible and acceptable to the patient.
5.2. When reviewing treatment options with the patient, clinicians should provide information about the potential benefits and harms of any treatment and check the patient's understanding of these benefits and harms. 96%	a. Include a discussion of the frequency and nature of clinic visits and/or hospital stays required for treatment and side effects of treatment. b. Frame treatment options in the context of the patient's goals and priorities. c. If appropriate, given goals of care and treatment preferences, include the option of collaboration with palliative care or changing from a cancer treatment focus to supportive treatment with or without hospice care (see Recommendation 4.5). d. Ensure that the patient has appointed a surrogate medical decision maker and discuss preferences about resuscitation efforts.
5.3. Discuss treatment options in a way that balances patient hope with a realistic assessment of likely outcomes, promotes autonomy, and facilitates understanding. 100%	a. Remind patients that they are the ultimate decision makers in their care. b. Focus on what <i>can</i> be done. c. Align patient goals, values, and care preferences with treatments and services offered. d. Reinforce a commitment to ongoing care, regardless of treatment choice. e. Acknowledge uncertainty. f. Normalize patient requests for a second opinion. g. Present information in small chunks and check in frequently to assess understanding. h. When available, use published decision aids to prepare patients for the conversation, and enhance patient education, communication, and shared decision making during consultations (see Recommendation 8.2). i. Whenever possible, include pertinent members of the interprofessional team. j. Document discussions in the health record.
5.4. Clinicians should make the patient aware of all treatment options, including established standard of care, clinical studies, and a focus on palliative care (see Recommendation 4.5). If clinical studies are available, clinicians should start treatment discussions with standard treatments available off trial and then move to a discussion of applicable clinical studies if the patient is interested. When appropriate, clinicians should discuss the option of initiating palliative care simultaneously with other treatment modalities. 100%	a. Explain what clinical studies are, why they are conducted, and the difference between experimental and standard clinical care. b. Clearly delineate treatment choices, including available standard treatments and investigational treatments. c. Explain what is known about the safety and efficacy data of the study treatment(s). d. Affirm that care will not be compromised if the patient decides not to participate in a clinical study. e. Allow patients and their support network time to give their reaction to the concept of clinical studies in general and the specific clinical study presented. f. Include discussion of symptom- or quality of life-directed care, such as palliative care or hospice, in conjunction with or as an alternative to cancer treatment if consistent with patient's goals or clinical scenario.

differences, professional, in-person interpreters are generally preferred to ad hoc interpreters.²⁴ Furthermore, the act of building trust with a patient, although important in all clinical encounters, may be particularly salient when language or cultural differences are present.^{35,48}

Three systematic reviews addressed cost-of-care discussions.^{32,50,57} Each highlighted the need for more specific guidance about how best to discuss cost and financial burden with patients. Evidence suggest that patients tend to be open to such discussions,³² and engaging in cost discussions may provide opportunities for patients and clinicians to manage financial burdens.⁵⁰

The importance of clinician training in communication skills was addressed by a 2018 Cochrane review that included 17 RCTs.⁷¹ Clinicians who received training were more likely to use open-ended questions, less likely to give facts only, and more likely to show empathy toward their patients. A 2021 systematic review of online communication skills training for cancer or palliative care professionals reported that such training improved clinicians' self-assessed skills,

confidence, and objective knowledge.⁴⁹ Less information is available about patient outcomes and the optimal format for training.^{62,67}

Outcome of the Formal Consensus Process

During the first round of voting by the Consensus Panel, agreement with each recommendation exceeded 75%, with one exception with 67% agreement. After reviewing the comments received during round 1 of voting, the Expert Panel chose to revise 36 of the original 46 recommendations and to delete two recommendations, including the one with the lowest level of agreement. After round 2 of voting on the revised recommendations, agreement with the full set of recommendations ranged from 81% to 100%. Final voting results are provided in [Tables 1-12](#).

RECOMMENDATIONS

Recommendations are provided in [Tables 1-12](#). The recommendations in the tables are directed toward clinicians. However, health systems must provide adequate time,

TABLE 6. Communication About End of Life

Recommendation and Level of Agreement	Strategies
6.1. Clinicians should use an organized framework to guide the bidirectional communication about end-of-life care with the patient and members of their support network. 92%	a. Use the principles and tools presented in published frameworks, such as SPIKES¹¹⁸ and the Serious Illness Conversation Guide.¹¹⁹ b. Prepare mentally for discussions by anticipating the emotions of the patient and their support network, as well as questions about topics such as prognosis. c. Review the health record for documentation of previous end-of-life discussions and decisions. d. Review information regarding previous end-of-life care discussions and decisions with the patient and whomever the patient would like to have included. This should include previous discussions and decisions about goals of care, cardiopulmonary resuscitation, hemodialysis, nutrition, hydration, and intensive care. e. Develop rapport with the patient and members of their support network. f. Ask patients and their support network about their preferences for information sharing. g. Ask the patient and their support network what they understand about their medical situation. h. Ask permission before sharing new medical information, including difficult news, prognostic information, or significant changes in treatment plan. i. Provide information in small amounts, using plain direct language, avoid medical jargon, and check understanding frequently. j. Use a question prompt list to assist the patient in establishing questions they may want to discuss. k. Address and express empathy for emotions throughout the conversation. l. Ask the patient and members of their support network to define their goals in light of the medical situation. What is most important to them? What are their priorities? Explore sources of support including spirituality and religious beliefs. m. Inquire if members of the patient's support network are aware of the patient's goals. n. When appropriate, inquire about patient's familiarity and understanding of hospice. Frame hospice services in the context of the patient's expressed goals (eg, "You stated being at home with your family is very important to you. Hospice is a program that focuses on keeping you at home and out of the hospital"). o. Summarize the conversation and establish a plan for the future. p. Document end-of-life conversations in the health record. q. For conversations incorporating highly complex, emotional, or high content load, spread the conversation over two or more visits.
6.2. Clinicians should initiate conversations about the patient's end-of-life preferences early in the course of incurable illness and readdress this topic periodically based on clinical events or preferences. 92%	Early in the course of incurable illness, within a month of diagnosis: a. Discuss prognosis and advance care planning. Consider asking if the patient has thought about a situation during which they might not be able to make or express a decision regarding health care (eg, "Advanced care planning allows us to discuss and document your wishes for treatment and care if you are unable to make medical decisions in the future due to illness or disability."). b. Document a surrogate decision maker and encourage the patient to complete an advance directive early in the course of disease (eg, "Have you ever thought about who you would designate to make decisions on your behalf should something happen that would make you unable to make your own decisions?"). c. Discuss why advance care planning is important and why the patient should discuss their goals, values, and care preferences with their appointed health care agent. Explain that this is a way to try to ensure that the care they receive is consistent with what they would want under different circumstances if they were not able to participate in decision making. d. Explore patient goals and values. e. Anticipate that patient goals and preferences may change over time in response to disease and treatment-related factors as well as physical and emotional changes. f. Recognize triggers or sentinel events that may prompt end-of-life care conversations with the patient in the setting of advanced disease, including • Cancer progression • Decline in functional status • Increased high-intensity health care utilization, including multiple emergency department visits, admissions to the hospital, ICU stays, or transition to a nursing facility if previously independent • Consideration of a new line of cancer-directed therapies in the setting of progression on or poor tolerance of previous treatments • Consideration of high-risk or high-burden medical or surgical interventions (eg, hemodialysis, palliative surgery, feeding tube placement) • Requests for care that do not align with the patient's clinical scenario • Requests from the patient or their supportive network for end-of-life care planning conversation
6.3. Clinicians should explore how a patient's culture, religion, or spiritual belief system impacts their end-of-life decision making or care preferences. 96%	a. Ask open-ended questions regarding the impact of a patient's culture and spirituality on their medical decision making. b. Avoid assumptions about a patient's end-of-life care preferences. c. Explore how a patient's lived experiences have shaped their end-of-life preferences. d. Use a standardized tool such as FICA¹²⁰ to assess a patient's spiritual or religious beliefs. e. When spiritual distress is identified, offer spiritual support from a medically trained chaplain, or explore with the patient who might offer support that would be meaningful to them.

(continued on following page)

TABLE 6. Communication About End of Life (continued)

Recommendation and Level of Agreement	Strategies
6.4. Health care teams should identify and suggest local resources to provide robust support to the patient, and members of the patient's support network when the patient transitions to end-of-life care. 97%	a. Introduce and describe palliative care services, including simultaneous palliative and oncology care, palliative care alone, and hospice care, when the disease becomes incurable. b. When a patient is transitioning to end-of-life care or hospice care, explore the goals and service needs of the patient and their support network. c. Be aware of cues that the patient might or might not be ready for such a discussion. d. Discuss concerns that family members and other members of the patient's support network may have, whose openness to hospice may differ from the patient's. e. When possible and with the patient's permission, include key family members or other members of the patient's support network by phone if they cannot be present.
6.5. Clinicians should recognize and respond empathically to grief and loss among the patient, the patient's support network, and the health care team. Clinicians should refer the patient and members of their support network to psychosocial team members (eg, social workers, counselors, psychologists, psychiatrists, and clergy) when appropriate. 96%	a. Recognize varied presentations of grief among the patient, the patient's support network, and colleagues. b. In response to anticipatory grief (eg, "What do I tell my kids?" "How will my family cope when I'm gone?"), explore patient concerns and refer the patient for appropriate psychosocial support. c. In response to patient descriptions of loss (eg, loss of role, income, identity, etc), explore meaning with the patient, acknowledge the loss through empathy, and refer for appropriate psychosocial support. d. Refer bereaved family members and other members of the patient's support network for grief counseling; identify local agencies, programs, and hospices that provide this service. e. After a patient death, convene a debriefing session for health care team members.

Abbreviation: FICA, Faith, Importance and Influence, Community, and Address; ICU, intensive care unit.

training, and support for clinicians to effectively execute these recommendations. Recommendations and terminology (see the Data Supplement) represent reasonable options for patients and clinicians depending on clinical circumstances and in the context of individual patient preferences. Recommended care should be accessible to patients whenever possible. Strength of recommendation is "Strong" for all: for recommendations supporting an intervention, the

desirable effects of an intervention outweigh its undesirable effects. All or almost all informed people would make the recommended choice for or against an intervention.

DISCUSSION

Improving health care communication in oncology remains a critical goal for institutions, clinicians, and the field of

TABLE 7. Involvement of the Patient's Support Network

Recommendation and Level of Agreement	Strategies
7.1. Clinicians should inquire about the desirability of involving the patient's support network in discussions about cancer and cancer treatment early in the course of the illness. 100%	a. Inquire about who constitutes the patient's support network, ensuring that the patient decides who in their network they want to participate in communication with the care team and what type of participation the patient desires. b. Establish rapport and lines of communication with the patient's support network. Identify a spokesperson if appropriate. c. Assess support networks' information needs and provide any information necessary to fill in gaps in knowledge. Tools such as CURVES¹²¹ can be helpful in making this assessment. d. Assess the patient's decisional capacity including assessing their memory, overall cognition, and ability to interpret information. e. If a patient lacks decisional capacity, ask the surrogate(s) about the wishes of the patient and facilitate decision making based on those wishes. f. Develop proficiency in conducting a family meeting (see Recommendation 7.2).
7.2. Determine if a formal family meeting in a hospital or outpatient setting is indicated at important junctures in care. When possible, ensure that the patient, their designated surrogates, and desired medical professionals are present. 96%	a. Prior to the meeting, designate a specific team member as chief facilitator for the meeting. b. Review medical record for previous discussions of goals of care and end-of-life directives. c. Introduce everyone present. d. Explore the agenda for the meeting of the patient's support network and state the clinician team's agenda in order to create a framework for the discussion and to ensure questions are answered directly. e. Share information about and/or documentation of previous discussions of goals of care and end-of-life directives. f. Elicit perspectives from all meeting attendees. g. Identify key issues and disagreements prior to problem-solving. h. Anticipate that in nonurgent situations, a resolution may not happen in the meeting itself. i. Pay attention to interactions (eg, who talks, to whom, and who is seen as a decision maker). j. Set a plan for follow up. k. Offer to include absent support network members via telecommunications, if appropriate. l. Document goals of care in the health record.

Abbreviation: CURVES, Choose and Communicate, Understand, Reason, Value, Emergency, Surrogate.

TABLE 8. Addressing Barriers to Communication

Recommendation and Level of Agreement	Strategies
8.1. If the patient or their support system do not share a common language with the clinician, use a medical interpreter rather than a family interpreter. 92%	a. Ask the interpreter if they are comfortable interpreting a conversation about cancer with the patient. If the interpreter is uncomfortable, it may lead to inappropriate translations due to emotional, religious, or other reasons. b. Use simple, clear sentences, pausing frequently to allow for interpretation. c. Look at the patient during conversations, not the interpreter. d. Ask the patient or members of their support network to describe what they have understood after you have explained something. e. Develop awareness of cultural differences, not just language differences (eg, some cultures do not maintain eye contact, some cultures may be more open to discussing changes of intensity of care, etc). f. Note that language barriers do not necessarily mean low health literacy, so allow for questions at the individual's literacy level (see Recommendation 8.2).
8.2. Focus on the most important points, use plain language, use a multimedia approach, and check frequently for understanding (see Recommendation 5.3). 92%	a. Assess health literacy with questions such as • How often do you fill out medical forms by yourself? • How well do you understand written and numerical information in relation to your health? • How important do you view your health care, and how much do you share responsibility for it with others? • What sources do you use to find information about your health? • How much control do you feel you have in relationships with your health care providers? b. Assess for any physical disability (eg, poor hearing or eyesight) that may affect the ability of the listener to understand the information the clinician is trying to convey. c. Ask the patient how they prefer to receive medical information (eg, verbally, in writing, with visual aids, big picture versus step-by-step details, etc). d. Encourage members of the patient's support network to take notes during the encounter. e. Ask the patient and their support network how comfortable they are with using technology. f. Supplement discussions and education with written materials, video, computerized interactive tools, online resources, apps, and/or in-person sessions. g. Be mindful of excessive use of apps and online resources, as it could deepen inequalities for those without access to technology. h. Assess understanding throughout the discussion (eg, teach back method) and before signing consents. i. Encourage questions to clarify communication. j. Use pictographs or other visual aids when available and describe absolute risk rather than relative risk. Written materials should be in plain language, use bulleted content, and contain images, graphs, or diagrams. k. Use materials that are designed for people with low health numeracy, and use both words and numbers, describe the meaning of the numbers, and explain risks and benefits of treatment.
8.3. For a patient with physical limitations that may affect communication, incorporate strategies appropriate for physical abilities. 96%	a. Tailor discussions to support patients' physical abilities. b. Use text or closed captioning for individuals with mild hearing loss or who are comfortable with written language. c. Use sign language interpreters for individuals who process information visually. d. For individuals with low vision or are blind, provide auxiliary aids, such as written materials with large print or with braille, and/or audio recordings. e. Ensure communication is directed at the patient, not the person accompanying the patient or the interpreter.

oncology. Definitions of ideal health care communication evolve as systems and processes for delivering care evolve. A significant shift over the past few decades has been the emergence of the electronic health record as a major and demanding presence in clinical settings that requires a substantial portion of clinicians' time and attention.^{94,95} Time spent charting, billing, and other forms of documenting is time not spent talking to and examining patients. Time spent staring at a screen is time not spent making eye contact. In this era, the chart may begin to seem more reliable or trustworthy than the patient.⁹⁶ There is a risk that clinicians' focus on the chart and test results distracts them from hearing the patient's narrative of their symptoms and their experience of their illness. If the patient's story is devalued, then incongruence between the patient's story and what's in the patient's chart can result in denigrating the patient rather than questioning the adequacy of our medical models and conceptualization of disease. The rapid adoption of telehealth video visits has

presented additional challenges by eliminating physical presence and touch from encounters. Prioritizing high-quality relationship-centered communication with patients of all backgrounds and identities is one way to keep the focus of oncology care on the patient rather than on the patient's chart.

This guideline delineates best practices for relationship-centered communication in oncology. Some are extremely basic, such as reviewing the patient's chart before seeing the patient, sitting down, making eye contact, and setting a mutually agreed-upon agenda at the start of visits. Yet, these may be neglected in the setting of a busy clinical day. Some require more skill and attention, such as actively listening, refraining from interrupting, and responding to emotion empathically. These practices help us tailor our approach to the individuals in front of us and help them feel seen and heard. Although they are absolutely critical to effective relationships and exemplary care in all of health

TABLE 9. Communication About Cost of Care

Recommendation and Level of Agreement	Strategies
9.1. Clinicians should explore whether cost of care, or nonmedical costs (eg, loss of income) are concerns for the patient. 92%	a. Discuss any specific concerns about cost of care and either address them or refer the patient and their support network to a financial counselor or social worker.
9.2. Clinicians should inquire if patients have difficulty with medical bills and if so, refer patients to reliable sources. 92%	a. When ordering diagnostic tests and treatment, inquire whether patients have access to information about costs so that they can make informed decisions about expenditures. Offer to refer them to appropriate resources.
9.3. Clinicians should be prepared to discuss the magnitude of benefit associated with tests and treatments they order so that patients can assess value based on the relationship between benefits and costs. 81%	a. Frame data in terms of absolute benefit rather than relative benefit (For instance, "For every 100 patients treated, an additional 5 will be alive 5 years later as a result of the treatment.").

care, few health systems prioritize effective training in communication skills, leaving interested individuals to seek training on their own with little to no support. We

emphasize that health systems must make effective communication a priority for everyone and provide time, training, and appropriate funding for these efforts (see

TABLE 10. Mitigating Stigma

Recommendation and Level of Agreement	Strategies
10.1. Enter clinical encounters with a sense of respectful curiosity, aware that any person, regardless of their background, may have beliefs, experiences, understandings, and expectations that differ from the clinician's. 92%	a. Investigate the benefits of longitudinal interactive training to improve self-awareness and knowledge about people with cultural backgrounds and experiences that may differ from one's own. b. Mirror the language of the patient and members of their support network about themselves, their bodies, their relationships, their communities, cancer, and cancer treatment. e. Solicit information about the patient's personal preferences and comfort with communication and social interaction f. Use language that is nonjudgmental and free of blame, bias, stigma, and stereotypes. g. Engage in relationship-building if a patient wishes, including questions about the patient's well-being and interests and experiences outside of cancer treatment.
10.2. Assess potential barriers to care for the patient, utilizing support as needed. 96%	a. Screen for health-related social needs and link to appropriate supports to address barriers to treatment. Use team support for resources (such as lawyers, social workers, interpreters, navigators, and financial specialists) when appropriate.
10.3. Remain aware that many patients have experienced adverse childhood events, as well as negative past health care and life experiences, including feeling disrespected, alienated, or unsafe, and respond with trauma-informed care. 97%	a. Develop familiarity with the trauma-informed care framework and use this approach to inquire about the patient's past experiences with health care systems and clinicians. Trauma-informed care is a framework that recognizes the importance of considering patients' past trauma to deliver care effectively.
10.4. Ensure that information needs are met and that the patient has the opportunity to participate in the decision-making process. 96%	a. Ask about preferred language for the encounter and ensure an interpreter is available if needed. b. Solicit information from the patient and their support network about their perspectives on cancer and its treatment, traditional knowledge from their communities on cancer and its treatment, and their communication preferences (eg, more information or less, autonomy or paternalism). c. Ensure use of lay language when communicating with the patient and their support network regarding cancer and its treatment (see Clinical Question 8). d. Consider providing the patient with question prompt lists to facilitate patients' ability to access needed information e. After providing information, check for understanding from the patient and their support network, and ask for follow-up questions. f. Investigate the utility of using decision aids, including pictorial aids, to facilitate shared decision making. g. Consider incorporating survivorship plans into clinic visits. These plans would provide culturally informed and linguistically appropriate information on topics such as treatment side effects, screening, pain management, fertility, culturally appropriate referrals, health behavior, and resources to meet psychosocial needs including those related to sexuality, finances, mental health, and others.
10.5. Recognize that when patients appear aggressive or respond with intensity, it could be a signal of unmet expectations, incomplete involvement in decision making, high emotional or care needs, or merely the inherent difficulty of the situation, and respond accordingly if able to do so while ensuring your own physical and emotional safety. 100%	a. Explicitly elicit patients' emotions and respond with empathy. b. Investigate the utility of receiving de-escalation training to improve communication and enhance safety. This could facilitate responding to heightened emotional states in patients by soliciting more information about patient and caregiver's communication and care needs and any barriers to meeting those.

Clinical Question 12). Not only is communication training the right thing to do but, at a system level, it leads to improved patient experience scores and decreased provider burnout.¹²⁻¹⁵

Best practices for interprofessional communication are addressed because strong and effective teamwork improves patient care, safety, and satisfaction.⁹⁷ The specific roles of nurse practitioners, physician assistants, and pharmacists, along with many additional clinicians, have increased, and the role of clinical nurses remains central to oncology care. Actively working to build and sustain high-quality teams characterized by psychological safety, respect for all members, accountability, and just processes is an essential part of delivering cancer care.

Aligning health care with an individual patient's goals, values, and priorities represents one of our core obligations, for which this guideline presents best practices. Effective patient education is key because people cannot make informed decisions without being informed, and patients often do not accurately understand their illness, their prognosis, or the prognostic implications of their test results. Providing medical information in a way that is accurate and understandable to laypersons, and that allows the patient to retain hope, is often challenging. Different patients may have very different needs and preferences, and tailoring our approach to the individual is necessary (see [Table 4](#) for relevant strategies). Communication about treatment options follows naturally from communication about goals of care. Skillfully addressing both domains facilitates shared decision making. The guideline also addresses skills and practices for communication about and at the end of life because of the specific needs patients and their loved ones have in that setting.

Because cancer affects not only the patient but also the people and systems surrounding them, other key issues addressed here include involvement of the patient's support network, barriers to communication, mitigating stigma, and setting boundaries. The Expert Panel suggests asking patients about their well-being, whether they have any safety concerns, and if they would like to talk about these, and how clinicians can best support them.

An important part of the cancer care team, the patient's support network, is often the first to notice symptoms of cancer progression or adverse effects of treatment. The patient's support network also often helps patients follow through with the care plan. Therefore, high-quality communication with the patient's support network, to the extent desired by the patient, is essential to ensuring quality care. Barriers to communication include lack of a shared language between patient and clinician, low health literacy, and a variety of disabilities, any of which can lead to inferior care.⁶⁴ Given the abundant published documentation of disparities in health care, using strategies to mitigate stigma is essential in oncology.^{98,99} [Table 10](#) outlines

practices for meeting each patient where they are and making all individuals feel welcome, respected, and seen. Health care costs are a burden to patients with cancer and can result in delayed and diminished treatment as well as financial hardship, emotional distress, and personal bankruptcy. Discussing cost of care is important, and the guideline provides guidance for doing so.

The final two tables of the guideline include suggestions for setting boundaries and training in communication skills. Boundaries are essential for maintaining clinicians' well-being in oncology. Clinicians have important responsibilities to patients and must set boundaries to sustain healthy relationships with patients and their support networks, and to avoid burnout and professional exhaustion. We also must set boundaries to avoid and minimize conflicts of interest in patient care. Finally, the guideline panel believes that strong communication skills mitigate against burnout and can be effectively taught and learned through well-designed experiential learning workshops; [Table 12](#) outlines recommendations for such sessions.

Though the literature search and recommendations in this guideline focus on patient-provider interactions in cancer, the broader literature suggests that there are four communication practices, which we name Universal Pillars of Communication, that can apply to nearly every conversation in health care ([Box 1](#)). Adoption of these practices with colleagues and all health care team members as well as patients and their support networks will not only deepen the relationships that are essential for optimal patient care but also emphasize the curiosity, empathy, respect, and compassion that we all must bring to the profoundly important work that we do—and to ourselves.

PRIORITIES FOR FUTURE RESEARCH

The salutary impacts of effective communication, and the harms of ineffective communication, in patient-clinician relationships have been validated since initial studies were published over three decades ago. However, even in the presence of optimal communication, numerous logistic factors influence patient outcomes, including structural barriers to treatment. Demonstrating a one-to-one causative effect of communication on any medical outcome is thus challenging. Surrogate markers, such as patient activation or health literacy, may be useful in measuring the impacts of effective communication^{100,101}; future research would benefit from identification and measurement of additional surrogate markers that correlate with health outcomes such as survival.

In addition, much recent research has focused on differences in delivery of oncologic health care depending on the demographics of the patient and their support systems for many (if not all) types of cancer.¹⁰²⁻¹⁰⁹ Treatment outcomes

BOX 1. UNIVERSAL PILLARS OF COMMUNICATION IN ALL HEALTH CARE CONVERSATIONS

1. Establish an environment that is conducive to collegial communication
 - Arrange for an appropriate location for the conversation and enough time to share information and answer questions
 - Have all the information necessary to conduct an effective encounter
 - Know who should be present for the conversation
 - Anticipate and prepare to assess the emotional responses of all conversation partners (including yourself)
 - Anticipate questions that might be asked
2. Collaboratively set an agenda
 - Use open-ended questions to encourage conversation partners to share what is important to them. For example, "What would you like to make sure we talk about today? I want to make sure we cover the issues important to all of us."
3. Actively foster trust and collaboration
 - Make time for everyone in the conversation to introduce themselves
 - Sit down
 - Be friendly and professional
 - Engage in reflective listening: refrain from interrupting and summarize the key elements of what you are hearing to ensure accurate understanding
 - Make eye contact
 - Maintain a calm demeanor
 - Be honest, genuine, and respectful
4. When conversation partners display emotion through verbal or nonverbal behavior, respond empathically
 - Observe, acknowledge, and name the emotions (eg, "I appreciate the anxiety we are all feeling about what to do next." "I am sensing the frustration in our conversation, and I am curious to hear more about it.")
 - Ask the conversation partner what they are most concerned about and explore what's behind strong emotions (eg, "Tell me what you are worried about.")
 - Use partnership and supporting statements (eg, "I want to work together to figure out the best plan." "This is what I can offer to help.")

should not diverge based on such differences, and these differences must therefore be further characterized and measures taken to reduce these gaps.

Finally, the landscape of health care will inexorably change with the use of generative artificial intelligence (GenAI).^{110,111} GenAI has already facilitated astonishing advances in information retrieval, diagnostic capability, and even inter-actational ability. The Expert Panel anticipates that GenAI will significantly influence interpersonal communication in health care settings; for example, documentation aided by GenAI may improve attention and nonverbal communication in real time. Conversely, patients may begin to access imperfect information or "hallucinations" from GenAI for decision making, which may deepen or reinforce patterns of medical misinformation and lead to challenges in clinician-patient relationships. This guideline will be published at the cusp of what may be an enormous shift in the way health care is delivered, and the Expert Panel suspects that the next set of communication guidelines may appear very different from these. Further work must determine methods of incorporating GenAI into clinical practice in a manner that optimizes patients' experiences and outcomes.

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

GUIDELINE IMPLEMENTATION

ASCO guidelines are developed for implementation across health settings. Each ASCO guideline includes a community oncologist member on the panel. The additional role of this community oncologist member on the guideline panel is to assess the suitability of the recommendations for implementation in the community setting, but also to identify any other barrier to implementation a reader should be aware of. Barriers to implementation include the need to increase awareness of the guideline recommendations among front-line practitioners and survivors of cancer and their support network, and to provide adequate services in the face of limited resources. The guideline recommendations table and accompanying tools (available at <https://ascopubs.org/topics/asco-guidelines/supportive-care-quality-life>) were designed to facilitate implementation of recommendations. This guideline will be distributed widely. ASCO guidelines are posted on the ASCO website and most often published in the *Journal of Clinical Oncology*.

TABLE 11. Setting Boundaries

Recommendation and Level of Agreement	Strategies
11.1. For boundary crossings by a patient, whether with the clinician themselves or observed with another team member (eg, clinical colleague, trainee), communicate clear expectations and set clear limits. 100%	a. Notice emotional discomfort that may arise because a patient's requests or actions may have crossed a boundary. b. Decide whether to address requests or actions that have crossed a boundary. c. If choosing to address the requests or actions, do so clearly, compassionately, and firmly. This may take several forms: for example, a curious question ("I wonder why you asked me that?") to determine the intention and context of a patient's actions, with space for the patient's response and compassionate listening; an "I" statement with an emotion ("When I hear you say that, I feel quite uncomfortable"); a firm reply ("As I am providing medical care to you, that is not something I can do"); among others. d. In cases of experiencing heightened emotion, give yourself permission to leave the interaction momentarily ("I need to excuse myself from this conversation for now"), and in that period, summon resources—from team members, security personnel, individual reflection, or through brief focus on the breath or meditation—so that returning to the interaction will allow you to address it more effectively. This "time out" also gives time for the patient to reflect on their actions. e. State clear expectations for the future ("In the future, I will not address further requests like this") and adhere to them. f. Debrief such interactions with trusted colleagues and team members, in individual settings or in small group meetings such as a Balint group.¹²²
11.2. Evaluate the ethical permissibility of one's own actions through an ethical framework. 96%	a. Before taking actions, determine that they are intended to benefit patients, rather than oneself. b. Evaluate whether an action might raise expectations to encourage future similar behaviors or be interpreted by others as inappropriately exhibiting bias or favoritism. c. Appraise the possibility and consequences of personal or professional entanglement—a clinician may become involved with a patient in a way that will negatively influence future medical care, to that patient or others. d. Discuss actions that may appear ethical with trusted colleagues even if those actions may not fully adhere to the previous strategies. Situational nuances are common; in fact, geographical differences in norms, attitudes, and practices exist.

TABLE 12. Communication Skills Training

Recommendation and Level of Agreement	Strategies
12.1. As part of their professional responsibility to continuously develop and improve their communication skills, clinicians should seek communication skills training that emphasizes sound educational principles including skills practice and experiential learning using role-play scenarios, and direct observation of patient encounters with coaching. 93%	a. Though lectures and online knowledge-based modules may enhance self-reported competency, they are by themselves ineffective methods of skills training and inadequate unless paired with supervised skills-practice exercises. b. Skills-practice exercises may include role-play sessions conducted by trained facilitators, or directly observed or videotaped interviews with real patients or standardized patients followed by targeted coaching. c. Skills-practice exercises should include structured feedback so that clinicians can learn which of their behaviors are effective and what opportunities exist to improve future performance.
12.2. For communication skills training to be most effective, it should foster practitioner self-awareness and situational awareness related to emotions, attitudes, and underlying beliefs and assumptions that may affect communication, as well as awareness of implicit biases that may affect interpersonal behaviors and decision making. 97%	Exercises to increase practitioner self-awareness and situational awareness may include. a. Reflection on the types of patient encounters that the clinician finds difficult, challenging, or unpleasant. b. Viewing videotapes of ineffective and exemplary communication skills behaviors, followed by structured prompts to stimulate reflection. c. Reflection on the elements of patient care that bring the clinician satisfaction or a sense of meaning. Asking clinicians why they chose to work in health care and what they find meaningful and rewarding in their work is an example. d. Reflection on personal experiences with the health care system as a patient or the loved one of a patient can increase both personal and situational awareness. e. Assuming the role of the patient or family member in role-play exercises to appreciate their perspective and emotional reactions and gain insight into effective communication responses. f. Brief mindfulness practices during the workday may help with self-awareness, reactivity, and equanimity in the face of suffering.
12.3. Facilitators of communication skills training should have sufficient training and experience to effectively model and teach the desired communication skills and facilitate experiential learning exercises. 97%	a. Facilitators should be familiar with the various modalities that enhance learner communication skills. b. Facilitators should be trained to conduct skills-based learning sessions so that participants learn in a psychologically safe setting, are adequately prepared to demonstrate the desired skills, and receive feedback aimed at improving future performance.

ADDITIONAL RESOURCES

For current information, including selected updates, supplements, and clinical tools and resources, visit <https://ascopubs.org/topics/asco-guidelines/supportive-care-quality-life>. Guideline recommendations are also available in the free ASCO Guidelines app (available for download in the [Apple App Store](#) and [Google Play Store](#)). Listen to key recommendations and insights from panel members on the [ASCO Guidelines podcast](#). The Methodology Manual (available at www.asco.org/guideline-methodology) provides additional information about the methods used to develop this guideline. Patient information is available at www.cancer.org.

ASCO welcomes your comments on this guideline, including implementation challenges, new evidence, and how this guideline impacts you. To provide feedback, contact us at guidelines@asco.org. Comments may be incorporated into a future guideline update. To submit new evidence or suggest a topic for guideline development, complete the form available at www.asco.org/guidelines.

INCLUSIVE LANGUAGE

ASCO is committed to promoting the health and well-being of all patients. ASCO guidelines are intended to apply to, and

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EQUAL CONTRIBUTION

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EDITOR'S NOTE

This ASCO Clinical Practice Guideline Update provides recommendations, with comprehensive review and analyses of the relevant literature for each recommendation. Additional information, including a supplement with additional evidence tables, clinical tools and resources, and links to patient information at www.cancer.org, is

RELATED ASCO GUIDELINES AND STANDARDS

- Palliative Care for Patients With Cancer¹¹² (<https://ascopubs.org/doi/10.1200/JCO.24.00542>)
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be discussed clearly and compassionately with, all patients. For this reason, guideline authors use appropriately inclusive language. In instances in which the guideline draws upon data based on research in a specified population (eg, studies regarding women with ovarian cancer), the guideline authors describe the characteristics and results of the research as reported.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Patient-Clinician Communication: ASCO Guideline Update

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Open Payments is a public database containing information reported by companies about payments made to US-licensed physicians ([Open Payments](#)).

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Open Payments Link: <https://openpaymentsdata.cms.gov/physician/844851>

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No other potential conflicts of interest were reported.

APPENDIX 1. GUIDELINE DISCLAIMER

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APPENDIX 2. GUIDELINE AND CONFLICTS OF INTEREST

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

TABLE A1. Patient-Clinician Communication Guideline Update Expert Panel Membership

Name	Affiliation	Role or Area of Expertise
Calvin L. Chou, MD, PhD (co-chair)	UCSF, Veterans Affairs Health Care System, San Francisco, CA	Internal medicine, communication
Timothy Gilligan, MD (co-chair)	Cleveland Clinic, Cleveland, OH	Medical oncology, communication
Ash B. Alpert, MD, MFA, ScM	Yale Cancer Center, Yale School of Medicine, New Haven, CT	Hematology/oncology, health services research
Nessa Coyle, NP, PhD	Memorial Sloan Kettering Cancer Center, New York, NY	Oncology nursing, palliative care
Seema Harichand-Herd, MD	Mission Blood + Cancer, Des Moines, IA	Hematology/oncology
Christopher S. Lathan, MD, MS, MPH	Dana-Farber Cancer Institute, Harvard Medical School, Boston, MA	Medical oncology
Evangelia Razis, MD, PhD	3rd Oncology Department, Hygeia Hospital, Athens, Greece	Medical oncology
Kimberly Rivera, DNP, RN-BC, OCN, NPD-BC	Oncology Nursing Society, Pittsburgh, PA	Oncology nursing
Tara Sanft, MD	Yale Cancer Center, Smilow Cancer Hospital, Yale School of Medicine, New Haven, CT	Medical oncology, hospice, and palliative medicine
Carole Seigel, MBA	Advocacy Representative, Brookline, MA	Advocacy representative
Melissa Times, MD	MetroHealth, Cleveland, OH	Surgery
Kari Bohlke, ScD	American Society of Clinical Oncology, Alexandria, VA	ASCO Practice Guideline Staff (health research methods)

TABLE A2. Patient-Clinician Communication Guideline Update Consensus Panel Membership

Name	Affiliation
Stewart C. Alexander, PhD	Purdue University, West Lafayette, IN
Wendy A. Allen-Rhoades, MD, PhD	Mayo Clinic, Rochester, MN
Mary Catherine Beach, MD, MPH	Johns Hopkins Medicine, Baltimore, MD
Cristiane Decat Bergerot, PhD, BS, MS	Oncoclinicas & Co—Medica Scientia Innovation Research (MEDSIR), Brasilia, Brazil
Eduardo Bruera, MD	The University of Texas MD Anderson Cancer Center, Houston, TX
Josephine Clayton, MBBS, PhD	Sydney Medical School, University of Sydney, Sydney, Australia
Jana Dickter, MD	City of Hope, Duarte, CA
Don S. Dizon, MD	Tufts Medical Center Cancer Center, Boston, MA
David W. Dougherty, MD, MBA	Abramson Cancer Center, Penn Medicine, Philadelphia, PA
Laura B. Esfeller, MA	Advocacy Representative
Nicole M. Grogan Fleege, MD	University of Iowa, Iowa City, IA
Stephanie L. Graff, MD	Brown University Health, Legorreta Cancer Center at Brown University, Providence, RI
Joshua AS Jones, MD, MA	Rochester Regional Health, Rochester, NY
Kathleen Kieran, MD, MSc, MME	Seattle Children's, Seattle, WA
Gretchen G. Kimmick, MD, MS	Duke University Medical Center, Durham, NC
Christopher J. Koenig, PhD	San Francisco State University, San Francisco, CA
Marcella Nunez-Smith, MD, MHS	Yale School of Medicine, New Haven, CT
Gary Rodin, MD	Princess Margaret Cancer Centre, University Health Network; University of Toronto, Toronto, ON, Canada
Debra Roter, DrPH, MPH	Johns Hopkins Bloomberg School of Public Health, Baltimore, MD
Shanthi Sivendran, MD, MBA, MScR	American Cancer Society, Atlanta, GA
Thomas J. Smith, MD	Johns Hopkins Sidney Kimmel Comprehensive Cancer Center, Baltimore, MD
Ishwaria M. Subbiah, MD, MS	Sarah Cannon Research Institute, Nashville, TN
Tammy Triglianios, AOCNP, ANP-BC, DNP	University of North Carolina, Chapel Hill, NC
Mazie Tsang, MD, MAS, MS	Mayo Clinic Comprehensive Cancer Center, Phoenix, AZ
Camille Valente, DNP, FNP	Atrium Health Levine Cancer Institute, Charlotte, NC
Mark Andrew Walshauser, MD	Cancer Care Specialists of Illinois, O'Fallon, Sparta and Highland, IL
Grant Richard Williams, MD, MPH	University of Alabama at Birmingham, Birmingham, AL
James E Williams, Jr., MS, Colonel (Ret.)	Advocacy Representative, Camp Hill, PA

NOTE. Disclosures of potential conflicts of interest provided by the consensus panel members are available in the guideline supplement.

TABLE A3. Recommendation Rating Definitions¹¹⁷

Term	Definition
Quality of evidence	
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.
Very Low	We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect.
Strength of recommendation	
Strong	In recommendations for an intervention, the desirable effects of an intervention outweigh its undesirable effects. In recommendations against an intervention, the undesirable effects of an intervention outweigh its desirable effects. All or almost all informed people would make the recommended choice for or against an intervention.
Conditional/Weak	In recommendations for an intervention, the desirable effects probably outweigh the undesirable effects, but appreciable uncertainty exists. In recommendations against an intervention, the undesirable effects probably outweigh the desirable effects, but appreciable uncertainty exists. Most informed people would choose the recommended course of action, but a substantial number would not.