Is clinical communication the one area of clinical oncology that needs no new ideas?

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XXX and we seek the same thing – clinical relationships in which clinicians are sensitive to the needs of the specific clinical context, the specific patient, and the specific moment in that patient's trajectory of care. But we have different views of the potential value of the evidence and theory in our review for clinicians wanting to learn how to achieve this sensitivity. Our reading of XXX's letter suggests three potential reasons for this divergence.

The first concerns contextual specificity. Our review focused on cancer care, but XXX seem not to. The paper that XXX cite to refute our findings that many people in acute cancer care prefer to avoid emotional talk in consultations does not provide the evidence that XXX claim, but does offer valuable clinical guidance[1]. One of its helpful suggestions is the value of doctors being primed to assess individual patients' needs around decision-making by first being aware of those of patients in general. That paper suggests, not that doctors generalize from this evidence to all patients they see, but that they use it as the starting point for enquiring about what specific patients might need. In that vein, our paper aimed to point clinicians and educators in cancer care to starting points that are closer to how most cancer patients see the consultation than are those provided by the current paradigm. However, XXX do not address what may be special about cancer and seem to see no benefit from ideas about how the immediate threat of mortality affects what patients need from clinical relationships. While they teach clinicians to be 'flexible' in communication, the body of knowledge and theory on which they call for this is generic. It offers little to inform flexibility because it does not distinguish whether patients seek minor elective surgery at leisure, potentially life-saving surgery in an acute crisis, or care at the end of life[2].

The second source of divergence concerns the role of theory. Attachment theory is over half a century old, researchers have been applying it to health care relationships for much of this time and there have been suggestions, long predating ours, that it could inform teaching for clinicians about the psychological processes that underpin clinical relationships[3]. Nevertheless, the latest edition of the textbook they cite contains no reference to attachment or other theories for understanding close or dependent human relationships. Similarly, whereas medical ethicists have long explored ideas about clinicians' goal-directedness[4], readers wondering how to engage with the communication and ethical dilemmas surrounding clinicians' multiple,

shifting, contextual and sometimes conflicting communication goals in cancer care might be disappointed by that textbook's brief account of generic and universal goals[2]. For XXX, it seems that the current paradigm is sufficient; clinical communication in cancer care is one area of clinical medicine that has nothing to gain by looking beyond its current conceptual borders. We agree that expert teachers are as sophisticated as XXX describe, and we anticipate that many will have very insightful ideas, informed by their experience, about how issues in our review might be addressed in practice. However, not all are so expert or yet so experienced that they need no guidance from communication theory. And even experts need to engage with theory if they want their practice to be scientific rather than a 'craft' or 'trade'. While rejecting our ideas, XXX seek support to expand the footprint of current educational practice. Arguably, if our discipline is to command the respect that this expansion will require from health professions and organisations, it will need to show the maturity of other specialties in being open to new thinking.

The third reason for divergence with XXX may be that we look at evidence differently. XXX say we were biased, which is an inevitable aspect of critical reviews that we explicitly acknowledged. But they overlook the contribution of such reviews. They dismiss ours as 'based primarily on [our] own qualitative studies', whereas we refer to over 40 qualitative papers, only 11 of which we authored (and we make no apologies for having done a lot of research in this field). From our perspective, a crucial strength of qualitative work is that there is no hiding behind numbers. The reader cannot escape the fact that participants said what they did. So our review shows that, when different qualitative researchers approach cancer patients in different tumour groups, in different countries, many of these patients say things that are hard to reconcile with current thinking in clinical communication. Despite claims to 'patient-centredness', XXX seem not to think we might learn from those voices – or, indeed, from the views of clinicians in some of those studies. Another contribution of qualitative work is to expose concepts that, while 'taken for granted' in large-N surveys, become more complex or confusing at the level of individual patients. For instance, while XXX cite survey evidence that patients prefer 'shared' decisions[5], this information is uninformative for practice because, as our review points out, qualitative evidence shows that diverse kinds of clinician communication allow patients to feel involved in decisions – even when they want their clinicians to make those decisions.

We and XXX also look differently at quantitative evidence in this field. XXX cite two trials on communication skills training as support for the *status quo*[6, 7]. It is puzzling that these are so widely cited in this way because their design and statistical analysis fall short of current standards for clinical trials and preclude confident conclusions. Neither specified a primary outcome, instead attaching this status to a basket of clinician behaviours. One originally reported improvement in only half of these behaviours[8]; the 12-month follow-up then claimed maintained gains but without the non-inferiority analysis necessary to show this confidently[6]. The other trial found no significant improvement across 10 behaviours (and one significant deterioration) despite discussing the training as if it had succeeded[7]. Moreover, crucially, neither of the reports that XXX cited reported whether patients benefited, relying on measurement of clinician behaviours that the research teams had designated as desirable – despite the failure of systematic reviews to find clear evidence that patients benefit when communication skills training increases the frequency of such behaviours[9]. Crucially, neither trial specified what frequency of the target behaviours was sought; without a target other than 'more', the scientific status of such papers is weak because readers can never know when the desired outcome has been achieved. Given these limitations, our interpretation is that that the generous way in which such weak or ambiguous evidence is often read and cited illustrates the self-maintaining nature of the current paradigm.

Our experience is that it is difficult to challenge dominant thinking in clinical communication without being perceived as critical of the career and practice of people who have worked hard to build communication research and teaching. The EACH presidential address which XXX cite seeks better links between educators, researchers and clinicians[10]. We offered our review in this spirit. The potential of such links will not be realized unless all parties engage with the challenges that ensue when people converge from different perspectives onto something as complex as clinical communication.

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