

Original Article

Cite this article: Korc-Grodzicki B, Alici Y, Nelson C, Alexander K, Manna R, Gangai N, Shen MJ, Parker PA, Banerjee SC (2020). Addressing the quality of communication with older cancer patients with cognitive deficits: Development of a communication skills training module. *Palliative and Supportive Care* **18**, 419–424. <https://doi.org/10.1017/S1478951520000218>

Received: 6 January 2020

Revised: 5 March 2020



Accepted: 15 March 2020

Keywords:

Cognitive syndrome; Communication skills training; Geriatrics; Oncology; Standardized patient assessments

Author for correspondence: Beatriz Korc-Grodzicki, Memorial Sloan Kettering Cancer Center, 1275 York Avenue, New York, NY 10065, USA. E-mail: korcrob@mskcc.org

Addressing the quality of communication with older cancer patients with cognitive deficits: Development of a communication skills training module

Beatriz Korc-Grodzicki, M.D., PH.D.¹, Yesne Alici, M.D.¹, Christian Nelson, PH.D.¹, Koshy Alexander, M.D.¹, Ruth Manna, M.P.H.¹, Natalie Gangai, B.S.¹, Megan J. Shen, PH.D.² , Patricia A. Parker, PH.D.¹ and Smita C. Banerjee, PH.D.¹ 

¹Memorial Sloan Kettering Cancer Center, 1275 York Avenue, New York, NY and ²Weill Cornell Medical College, New York, NY

Abstract

Objective. Effective communication is an essential part of patient-centered care. The complexity of cancer care in older adults makes communication challenging, particularly when older patients have cognitive deficits and lose their autonomy. This paper describes the development, implementation, and evaluation of a communication skills training module for health care providers (HCPs) who work with older adults with cancer, with or at risk of developing cognitive deficits.

Method. Using a pre-post single arm study design, 99 HCPs from a comprehensive cancer center in North-East USA, who worked primarily with geriatric patients, participated in the study. Participants included Advance Practice Providers (including Nurse Practitioners and Physician Assistants; $n = 24$, 24.2%); nurses ($n = 23$, 23.2%), social workers ($n = 14$, 14.1%), physicians ($n = 13$, 13.1%), and “other” HCPs (including occupational therapists, physical therapists, and psychologists; $n = 20$, 20.2%). The HCPs participated in a one-day geriatric communication skills training program in groups of 12–15 over a 2-year period. Participants complete pre-post surveys on module evaluation and perception of self-efficacy as well as pre-post video-recorded Standardized Patient Assessment (SPA) to evaluate communication skill uptake.

Results. Most participants evaluated the module positively; over 90% indicated that they agreed or strongly agreed with five of the six module evaluation items. HCPs’ self-efficacy in communicating with cancer patients with cognitive deficits significantly increased from pre- to post-module training. There was a significant increase in the following communication skill use from pre- to post-training: checking patient preferences, declaring agenda, and inviting agenda.

Significance of results. Results demonstrated a successful implementation of the program as evidenced through favorable program evaluation, significant gains in self-efficacy, as well as significant improvement in several communication skills.

Introduction

Effective communication is critical to the successful delivery of health care services and is an essential part of patient-centered care. The Institute of Medicine (IOM)’s 2001 report *Crossing the Quality Chasm* identified patient-centeredness as one of six core elements of high-quality health care and defined it as “providing care that is respectful of and responsive to individual preferences, needs, and values and ensuring that patient values guide all clinical decisions” (Institute of Medicine, 2001). The importance of effective communication between health care providers (HCPs) and patients has also been highlighted by the Joint Commission. It recommends an approach to communicating health information that encompasses language and cultural needs, individual understanding, and other communication issues (Joint Commission, 2011). Several studies have found that sub-optimal communication has detrimental effects on patients and may increase their levels of uncertainty, anxiety, and dissatisfaction with care (Hagerty et al., 2005; Donovan-Kicken and Caughlin, 2011), may increase lack of compliance with recommended treatment regimens (Jin et al., 2008), and is associated with poorer quality of life (Kerr et al., 2003).

The complexity of cancer care in older adults makes communication very challenging (Schroyen et al., 2014). It becomes more difficult when older patients have sensory losses (vision or hearing impaired) and becomes extremely challenging when older patients have cognitive deficits and begin losing their autonomy and independence. Ageism may become

more evident when a third person is involved in the HCP-patient encounter. Issues of privacy may need to be addressed and the HCP's own biases need to be overcome. These challenges affect not only the patient, but also caregivers, clinicians, and all treatment team members (Amalraj et al., 2009).

Cognitive syndromes are commonly encountered among older adults with cancer and the incidence increases as we age (Lawlor et al., 2000). Factors such as primary or metastatic brain tumors, delirium, comorbid depression, medical comorbidities, or adverse effects of treatments such as chemotherapy and radiation can predispose patients to developing cognitive deficits (Andreotti et al., 2015a). An important issue at the intersection of cancer and dementia is that cognitive deficits in older adults influence outcomes in cancer care. Cancer patients with cognitive impairment are at increased risk of functional dependence, treatment non-adherence, and are at greater risk of death (Hurria et al., 2014). The National Comprehensive Cancer Network (NCCN) Older Adult Oncology Guidelines recommends the assessment of cognitive function for all older adults when considering a cancer treatment plan (NCCN, 2019). Once cognitive impairment is identified, HCPs need to assess for underlying etiologies to identify reversible and irreversible contributing factors, assess decision-making capacity, and revise goals of care.

It is crucial that the oncology care teams know how to communicate appropriately with patients across circumstances and settings to provide accurate information, assess accurate patient understanding, and decrease the possibility of errors. Training oncology HCPs in these principles and skills remains a challenge with a dearth of geriatric communication training programs.

The Communication Skills Training and Research Laboratory at Memorial Sloan Kettering Cancer Center (MSK) was created to train providers in communication skills to support the patient throughout the cancer disease trajectory. As such, we saw the need to train HCPs in the subject of communication with the older cancer patient who presents with cognitive impairment. We developed, implemented, and evaluated a communication skills (Comskil) training program for HCPs who work with older adults with cancer. An interprofessional team developed this training program following the same conceptual and methodological approach used in prior Comskil training programs developed for oncologists (Bylund et al., 2010, 2011; Bialer et al., 2011; Banerjee et al., 2017). The *Communicating with Older Cancer Patients with Cognitive Deficits* module was developed as one of three modules that make up a day-long Geriatric Communication Skills Training Program. The other two modules are: "Geriatrics 101" which focuses on ageism and frequent geriatric syndromes and "Shared Decision Making" which focuses on the difficulties of making clinician-patient-caregiver shared decisions in the context of cognitive decline.

The aims of this study are to describe the content of the *Communicating with Older Cancer Patients with Cognitive Deficits* module, assess HCP satisfaction with the module, uptake of communication skills, and their confidence in recognizing and addressing cognitive deficits and a lack of decision-making capacity that may influence the medical care of older adults with cancer.

Methods

Modular content

The goals of the module *Communicating with Older Cancer Patients with Cognitive Deficits* are: (a) to discuss cognitive

syndromes in older adults with cancer, (b) to address patient/family questions and concerns related to potential cognitive and functional decline as a result of cancer treatment, and (c) to assess decision-making capacity in older adults with cancer who present with cognitive syndromes or who are at increased risk of cognitive decline. Using the established Comskil conceptual framework (Kissane et al., 2012), this module proposes eight strategies, along with communication skills and process tasks, summarized in Table 1.

Participants and procedure

Ninety-nine HCPs who worked primarily with geriatric patients were trained in groups of 12–15 over a 2-year period. Participants included Advance Practice Providers (including Nurse Practitioners and Physician Assistants; $n = 24$, 24.2%); nurses ($n = 23$, 23.2%), social workers ($n = 14$, 14.1%), physicians ($n = 13$, 13.1%), and "other" HCPs (including occupational therapists, physical therapists, and psychologists; $n = 20$, 20.2%). Participants ranged in age from 24 to 69 years ($M = 39.78$, $SD = 14.22$) and were predominantly female (83.8% females). Half of the participants were White (50.5%) with 20.2% Black, 11.1% Asian, 6.1% bi-/multi-racial, and 12.1% others. MSK's Institutional Review Board approved this educational study and the publication of these data.

Training format

The training combined a didactic presentation with experiential role-play to practice the communication skills learned. It entailed a 30-min frontal lecture presenting the literature on cognitive syndromes encountered in older adults with cancer, a review of commonly used cognitive assessment tools, a description of decision-making-capacity assessment, and strategies for communicating with older adults with cancer with cognitive deficits. Exemplary videos were embedded into the didactic presentation to illustrate key communication skills. The presentation was followed by small-group experiential role-play (90 min), with three participants per small-group role-play. Trained facilitators led the small-group role-play sessions in which simulated patients (SP; trained actor) followed pre-scripted roles of a geriatric patient and caregiver posing communication challenges due to cognitive deficits. Each participating HCP was asked to identify their learning objective and practice specific strategies (Table 1) with the simulated patient and caregiver dyad, and frequent timeouts were used to invite reflection.

Standardized patient assessment

A subset of 86 participants (86.87%) completed a 12-min video recorded interaction simulating an encounter between an HCP and a geriatric simulated patient and his/her simulated caregiver. This SPA was completed both pre- and post-training. Given that the day-long Geriatric Communication Skills Training Program included three modules (Geriatrics 101, Cognitive Syndromes, and Geriatric Shared Decision Making), we randomized participants to complete a module-specific SPA. As such, 27 participants (of the 86 participants that completed an SPA) were assigned to the Cognitive Syndromes SPA that simulated an encounter between a HCP and a geriatric simulated patient with cognitive deficits and his/her caregiver.

Table 1. Modular blueprint for communicating with older cancer patients with cognitive deficits

Strategies	Skills	Process Tasks
1. Welcome and set agenda collaboratively: the clinician strives to set the structure and initiate the interaction with patient and caregiver (if present)	<ul style="list-style-type: none"> - Declare Agenda - Invite Agenda - Negotiate Agenda (if appropriate) 	<ul style="list-style-type: none"> - Make introductions - Arrange seating, if needed - Sit at eye level
2. Establish the physician-patient-family team: focuses on rapport formation and on creating an inviting consultation space for the patient and caregiver	<ul style="list-style-type: none"> - Endorse question asking - Check patient preference 	<ul style="list-style-type: none"> - Introduce joint decision making - Make partnership statements
3. Develop a shared understanding of the patient's treatment experience so far: focuses on assessment of how much the patient and caregiver know/understand about the disease	<ul style="list-style-type: none"> - Check understanding - Ask open questions - Clarify - Restate 	<ul style="list-style-type: none"> - Talk to the patient, not about them (with other family members) - Gain an in-depth understanding of the patients' emotions and/or experience.
4. Discuss patient's cognitive and functional status: focuses on the mental status of the patient and his/her daily function	<ul style="list-style-type: none"> - Check patient preference - Acknowledge - Ask open questions 	<ul style="list-style-type: none"> - Test the patient's cognitive status using a cognitive assessment tool and/or asking about the patient's ability to perform activities of daily living independently
5. Assess decision-making capacity: focuses on patient's ability to make decisions about his/her treatment	<ul style="list-style-type: none"> - Check patient preference - Acknowledge - Take stock 	<ul style="list-style-type: none"> - Assessment of patients' decision-making capacity include the following: <ul style="list-style-type: none"> • Patient's understanding of relevant information • Patient's ability to appreciate the current situation and its consequences • Patient's capability to manipulate medical information rationally • Patient's communication of a consistent choice
6. Respond empathically to patient's treatment experience: focuses on the use of communication skills to help patients feel understood and supported	<ul style="list-style-type: none"> - Encourage expression of feelings - Acknowledge - Validate - Praise efforts 	<ul style="list-style-type: none"> - Maintain eye contact - Allow time to integrate; use silence - Offer tissues - Repeat as often as necessary
7. Present preliminary clinical observation: focuses on elicitation of a clear recommendation	<ul style="list-style-type: none"> - Summarize - Invite questions - Endorse question asking 	<ul style="list-style-type: none"> - Present clear elicitation of clinician's observation and recommendation - Offer decision delay
8. Close meeting by final review of agreed goals of care and future plans: focuses on closing the consultation with agreed next steps	<ul style="list-style-type: none"> - Check understanding - Summarize - Review next steps 	<ul style="list-style-type: none"> - Arrange next appointment - Offer to help tell others or respond to their questions - Reinforce joint decision making

Note. The goals are to (a) discuss cognitive syndromes in older adults with cancer, (b) address patient/family questions and concerns related to potential cognitive and functional decline as a result of cancer treatments, and (c) assess decision-making capacity in older adults with cancer who present with cognitive syndromes or who are at increased risk of cognitive decline.

Evaluation

All participants completed pre-post surveys for each module with the following two goals: evaluation of the module and assessment of self-efficacy. Additionally, 27 participants completed pre- and post-training, 12-min video recorded interaction with the standardized patient (SPA).

Module evaluation

Evaluation of the module included six statements using five-point Likert-type scales (1 = "strongly disagree" and 5 = "strongly agree") assessing participants' levels of agreement or disagreement with each statement. In addition, participants rated four key

components of training (booklet, didactic teaching, exemplary videos, role play experience) on a three-point Likert-type scale (1 = "did not aid my learning at all" and 3 = "aided my learning a lot").

Self-efficacy

Pre-post training perception of self-efficacy was measured using a five-point Likert-type scale (1 = "strongly disagree" and 5 = "strongly agree") in two statements: (a) "I feel confident in my ability to recognize cognitive syndromes in older adults with cancer" and (b) "I feel confident in my ability to appreciate communication challenges in the decision-making process when the patient is cognitively impaired."

Table 2. Participant evaluation of communicating with older cancer patients with cognitive deficits module ($N = 99$)

Course evaluation items	M^a (SD)	Endorsement ^b N (%)
1. I feel confident that I will use the communication skills I learned today.	4.54 (0.52)	97 (98.0%)
2. The skills I learned today will allow me to provide better geriatric patient care.	4.55 (0.54)	96 (97.0%)
3. The workshop prompted me to critically evaluate my own communication skills.	4.63 (0.51)	97 (98.0%)
4. The experience of observing the role play was helpful to the development of my skills.	4.47 (0.61)	92 (92.9%)
5. The skills I learned were reinforced through the feedback I received as a participant in the role play.	4.64 (0.50)	89 (90.0%)
6. The group facilitators were effective.	4.65 (0.52)	95 (96.0%)
Modular components		
7. Booklet	2.37 (0.66)	84 (84.8%)
8. Didactic	2.64 (0.54)	94 (94.9%)
9. Exemplary video	2.79 (0.43)	96 (97.0%)
10. Role play experience	2.90 (0.31)	97 (98.0%)

Note. ^aItems 1–6 were scored on a 5-point Likert scale with anchors at (1) Strongly disagree to (5) Strongly agree; Items 7–10 were scored on a 3-point scale with anchors at (1) Did not aid my learning at all to (3) Aided my learning a lot.

^bEndorsement refers to the number of participants that responded “Agree” or “Strongly agree” for Items 1–6; and “Aided my learning somewhat” or “Aided my learning a lot” for Items 7–10.

Communication skill uptake

The participants that completed the 12-min SPA on the given clinical scenario were evaluated by two trained blind coders who coded the SPA videos using the Comskil Coding System (Bylund et al., 2011).

Data analysis

For module evaluation, a rating of agree or strongly agree was considered to be an indicator of satisfaction with the module and was analyzed descriptively. For assessing perception of improvement in self-efficacy, paired t tests were used to assess significant differences. Finally, for measuring increase in communication skills uptake using the SPAs, frequency of individual skills was used as the unit of measurement, and paired t tests were used to assess changes in outcomes from pre- to post-training.

Results

Results on module evaluation

Overall, participants rated the module favorably. Specifically, more than 90% of the participants indicated that they agreed or strongly agreed with five of the six evaluation items (with one item receiving endorsement by more than 85% but less than 90% of participants). In addition, three of the four modular components (didactic teaching, exemplary videos, role play experience) were rated favorably, with over 90% participants agreeing that the modular components aided in their learning (booklet was endorsed favorably by approximately 85% participants) (Table 2).

Improvements in self-efficacy

Participants' self-efficacy regarding the item, “I feel confident in my ability to recognize cognitive syndromes in older adults with cancer” significantly improved [$t(96) = -9.93$, $P < 0.001$] from pre- ($M = 3.28$, $SD = 0.94$) to post-module training ($M = 4.16$, $SD = 0.65$). As well, participants' self-efficacy regarding the item,

“I feel confident in my ability to appreciate communication challenges in the decision-making process when the patient is cognitively impaired” significantly improved [$t(96) = -6.37$, $P < 0.001$] from pre- ($M = 3.71$, $SD = 0.98$) to post-module training ($M = 4.37$, $SD = 0.55$). Thus, participants' overall self-efficacy in communicating with geriatric cancer patients with cognitive deficits significantly increased from pre- to post-module training.

Communication skill uptake

There was a significant increase in overall communication skills use from pre- to post-training. Overall, skill uptake increased in three skill categories — agenda setting, checking, and information organization. Participants demonstrated clear uptake of three individual skills — declare agenda, invite agenda, and check preference. Additionally, the overall skill usage increased from pre- to post-training (Table 3).

Discussion

Age is the most important risk factor for developing cancer and demographic changes in the United States will result in a marked increase in the number of cancer diagnoses over the next 20 years (Smith et al., 2009). Older adults are at increased risk of suffering cognitive syndromes at the time of cancer diagnosis and are more likely to experience worsening cognitive decline during cancer treatment with a significant impact on clinical outcomes and patient's autonomy and quality of life (Lange et al., 2014). Cognitive dysfunction, more commonly encountered in the older population, is a new challenge for oncologists and other HCPs that interact with elderly cancer patients. In this study, we have described the content of the *Communicating with Older Cancer Patients with Cognitive Deficits* module and presented data on HCPs' satisfaction with the module, uptake of communication skills, and perception of self-efficacy in recognizing cognitive syndromes and appreciating communication challenges in the decision-making process when the patient is cognitively impaired. Results demonstrated a successful implementation of the program as evidenced through favorable

Table 3. Communicating with older cancer patients with cognitive deficits module communication skill uptake (SPA skills coding) ($N = 27$)

Skills	Pre-training <i>M</i> (SD)	Post-training <i>M</i> (SD)	<i>t</i> (<i>df</i> = 26)
Agenda setting	0.26 (0.53)	0.96 (0.94)	-3.22**
Declare agenda	0.19 (0.40)	0.56 (0.51)	-2.80**
Invite agenda	0.07 (0.27)	0.33 (0.56)	-2.05*
Negotiate agenda	0.00 (0.00)	0.07 (0.27)	-1.44
Take stock	-	-	-
Checking	0.93 (1.36)	1.52 (1.01)	-2.02*
Check understanding	0.74 (1.29)	0.74 (0.81)	0.00
Check preference	0.19 (0.40)	0.78 (0.85)	-3.86***
Questioning	5.89 (2.91)	6.52 (2.06)	-1.10
Ask open questions	4.22 (2.36)	4.07 (1.90)	0.27
Clarify	0.89 (1.16)	1.00 (0.83)	-0.42
Restate	0.37 (0.79)	0.78 (1.19)	-1.39
Endorse question asking	0.00 (0.00)	0.04 (0.19)	-1.00
Invite questions	0.41 (0.89)	0.67 (0.96)	-1.32
Information organization	0.41 (0.64)	0.85 (0.95)	-2.28*
Preview	0.00 (0.00)	0.07 (0.27)	-1.44
Summarize	0.04 (0.19)	0.11 (0.32)	-1.44
Transition	0.11 (0.32)	0.26 (0.53)	-1.44
Review next steps	0.26 (0.53)	0.41 (0.57)	-1.07
Empathic communication	1.89 (1.87)	2.31 (2.04)	-0.74
Encourage expression of feelings	0.52 (0.75)	0.44 (0.89)	0.31
Acknowledge	0.41 (0.69)	0.44 (0.75)	-0.18
Validate	0.67 (1.14)	0.74 (0.98)	-0.32
Normalize	0.07 (0.27)	0.33 (0.62)	-1.89^
Praise patient efforts	0.22 (0.42)	0.33 (0.48)	-0.83
All skills	9.37 (3.83)	12.15 (3.53)	-2.59*

^ $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

program evaluation, significant gains in self-efficacy as well as significant improvement in several communication skills.

The HCPs reported significant improvement in their confidence to recognize cognitive syndromes in older adults with cancer. Despite the high prevalence, cognitive syndromes frequently go unrecognized in older adults with cancer (Andreotti et al., 2015b). Validated cognitive assessment tools should be used to screen these patients for cognitive deficits and to identify those who require a referral for additional evaluation (McKoy et al., 2014). In addition to recognizing cognitive syndromes, serial assessments using the same instrument could help track changes throughout treatment. It is important that clinicians acquire or improve the necessary skills to communicate with the patient and caregiver the importance of completing this screening.

The most effective method for learning communication skills is observation of ideal and effective strategies, followed by rehearsing the skills (Bylund et al., 2010, 2011). In the role-play, HCPs

were encouraged to rehearse and demonstrate skills in screening for cognitive impairment and differentiating between acute changes in cognition and long standing cognitive impairment. The ability to differentiate between acute versus chronic cognitive impairment is instrumental in caring for this patient population given high rates of medical comorbidity and increased risk for delirium. An acute change in mental status is associated with significant morbidity and mortality (Inouye et al., 2014).

Cognitive deficits may interfere with treatment decisions. Determination of decision-making capacity is a complex construct, yet critical when obtaining informed consent for assessments, treatment planning as well as participation in clinical research (Saracino et al., 2017). This challenge arises across the cancer continuum with several critical points in which it becomes necessary to evaluate and reevaluate the patient's ability to make sound decisions, such as at the time of consent for procedures or when making decisions for chemotherapy (Saracino et al., 2017). If patients can comprehend and apply general information about issues regarding medical decisions, they are presumed to be able to make medical decisions on their own behalf (Wilkins et al., 2009). This module emphasizes the assessment of patients' understanding of relevant information, their ability to appreciate their current situation and its consequences, and their capability to manipulate medical information while rationally communicating a consistent choice. A recent study comparing the use of a standardized tool for assessment of decision-making capacity versus clinician assessment revealed that the agreement between physician-rated capacity and performance on the standardized tool was poor (Kolva et al., 2018). Therefore, it is paramount to educate clinicians to appreciate the communication challenges around the decision-making process.

Significant increases in skill uptake were not observed for all skill categories. The largest gains were observed in checking patient preferences, declaring agenda, and inviting patient agenda. This is an interesting yet not a surprising finding given the dearth of geriatric education HCPs are exposed to throughout their training (Thomas et al., 2003; Weiss and Fain, 2009) and the lack of experience navigating multiple, sometimes vague complaints. Older adults frequently are faced with ageism — stereotyping and discriminating against individuals based on their age (Palmore, 2015). Ageism can impair communication and lead to suboptimal care, more so in the cognitively impaired (Adelman et al., 2000). Education of HCPs about aging-related issues increases knowledge and reduces ageism and negative stereotypes about aging (Palmore, 2015). Taking additional time during the clinical encounter to check patient preferences allows patients to exercise their autonomy — even in cognitively impaired patients — to the extent that they can. Declaring agenda and inviting agenda bring about a structure to the clinical encounter improving patient engagement. Therefore, the improvements observed in the communication skills were a welcome finding emphasizing the importance of providing this training to HCPs caring for older adults with cancer with cognitive deficits.

Limitations

This study has several limitations. It was carried out at one cancer center in North-East USA. Results may not be generalizable to other institutions; future research should also examine how to adapt this educational module to other educational settings. We limited our evaluation of the program to self-report and demonstration of behavior in a structured setting and did not examine

uptake of skills in clinic or at the bedside with actual patients. Future research should examine how HCPs use the newly learned skills when communicating with patients and their caregivers and assess the impact of the training on patient-reported outcomes.

Conclusions

This study demonstrated a successful implementation of a communication skills training program for HCPs, as substantiated through favorable program evaluation, significant gains in self-efficacy, as well as in several communication skills. Future research should focus on broader implementation and examination of the impact of training real-world use of communication skills with patients and on quality of care as determined by patient-reported outcomes.

Acknowledgments. This publication was made possible by Grant Number #U1QHP28705 from the Health Resources and Services Administration (HRSA), an operating division of the U.S. Department of Health and Human Services, Cancer Center Support Grant (CCSG-Core Grant; P30 CA008748; PI: Craig B. Thompson, MD), Rosanne H. Silbermann Foundation and Muriel Duenewald Lloyd Inspiration Fund. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Health Resources and Services Administration, the U.S. Department of Health and Human Services, the National Institutes of Health (NIH), or the above foundations.

References

- Adelman RD, Greene MG and Ory MG (2000) Communication between older patients and their physicians. *Clinics in Geriatric Medicine* **16**(1), 1–24. vii. doi:10.1016/s0749-0690(05)70004-5
- Amalraj S, Starkweather C, Nguyen C, et al. (2009) Health literacy, communication, and treatment decision-making in older cancer patients. *Oncology* **23**, 369–375.
- Andreotti C, Root JC, Alici Y, and Ahles T. (2015a) Cognitive disorders and delirium. In Holland J, Wiesel TW, Nelson CJ, Roth AJ, Alici Y (eds), *Geriatric Psycho-Oncology: A Quick Reference on the Psychosocial Dimensions of Cancer Symptom Management*. New York, NY: Oxford University Press, pp. 51–58.
- Andreotti C, Root JC, Ahles TA, et al. (2015b) Cancer, coping, and cognition: A model for the role of stress reactivity in cancer-related cognitive decline. *Psychooncology* **24**, 617–623. doi:10.1002/pon.3683
- Banerjee S, Manna R, Coyle N, et al. (2017) The implementation and evaluation of a communication skills training program for oncology nurses. *Translational Behavioral Medicine* **7**, 615–623. doi:10.1007/s13142-017-0473-5
- Bialer PA, Kissane D, Brown R, et al. (2011) Responding to patient anger: Development and evaluation of an oncology communication skills training module. *Palliative & Supportive Care* **9**, 359–365. doi:10.1017/S147895151100037X
- Bylund CL, Brown RF, Gueguen JA, et al. (2010) The implementation and assessment of a comprehensive communication skills training curriculum for oncologists. *Psychooncology* **19**, 583–593. doi:10.1002/pon.1585
- Bylund CL, Brown RF, Bialer PA, et al. (2011) Developing and implementing an advanced communication training program in oncology at a comprehensive cancer center. *Journal of Cancer Education* **26**, 604–611. doi:10.1007/s13187-011-0226-y
- Donovan-Kicken E and Caughlin JP (2011) Breast cancer patients' topic avoidance and psychological distress: The mediating role of coping. *Journal of Health Psychology* **16**, 596–606. doi:10.1177/1359105310383605
- Hagerty RG, Butow PN, Ellis PM, et al. (2005) Communicating with realism and hope: Incurable cancer patients' views on the disclosure of prognosis. *Journal of Clinical Oncology* **23**, 1278–1288. doi:10.1200/JCO.2005.11.138
- Hurria A, Dale W, Mooney M, et al. (2014) Designing therapeutic clinical trials for older and frail adults with cancer: U13 conference recommendations. *Journal of Clinical Oncology* **32**, 2587–2594. doi:10.1200/JCO.2013.55.0418
- Inouye SK, Westendorp RG and Saczynski JS (2014) Delirium in elderly people. *Lancet* **383**, 911–922. doi:10.1016/S0140-6736(13)60688-1
- Institute of Medicine (US) Committee on Quality of Health Care in America (2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK222274/> doi: 10.17226/10027
- Jin J, Sklar GE, Min Sen Oh V, et al. (2008) Factors affecting therapeutic compliance: A review from the patient's perspective. *Therapeutics and Clinical Risk Management* **4**, 269–286. doi:10.2147/tcrm.s1458
- Joint Commission (2011) *Patient-Centered Communication Standards for Hospitals. R³ Report*, 1. Available at: <https://www.jointcommission.org/standards/r3-report/r3-report-issue-1-patient-centered-communication/>
- Kerr J, Engel J, Schlesinger-Raab A, et al. (2003) Communication, quality of life and age: Results of a 5-year prospective study in breast cancer patients. *Annals of Oncology* **14**, 421–427. doi:10.1093/annonc/mdg098
- Kissane DW, Bylund CL, Banerjee SC, et al. (2012) Special series (Whole patient): Communication skills training for oncology professionals. *Journal of Clinical Oncology* **30**, 1242–1247. doi:10.1200/JCO.2011.39.6184
- Kolva E, Rosenfeld B and Saracino R (2018) Assessing the decision-making capacity of terminally ill patients with cancer. *American Journal of Geriatric Psychiatry* **26**, 523–531. doi:10.1016/j.jagp.2017.11.012
- Lange M, Rigal O, Clarisse B, et al. (2014) Cognitive dysfunctions in elderly cancer patients: A new challenge for oncologists. *Cancer Treatment Reviews* **40**, 810–817. doi:10.1016/j.ctrv.2014.03.003
- Lawlor PG, Gagnon B, Mancini IL, et al. (2000) Occurrence, causes, and outcome of delirium in patients with advanced cancer: A prospective study. *Archives of Internal Medicine* **160**, 786–794. doi:10.1001/archinte.160.6.786
- McKoy JM, Burhenn PS, Browner IS, et al. (2014) Assessing cognitive function and capacity in older adults with cancer. *Journal of the National Comprehensive Cancer Network* **12**, 138–144. doi:10.6004/jnccn.2014.0011
- National Comprehensive Cancer Network® (NCCN) (2019) NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Older Adult Oncology, Version 1.2019. Available at: https://www.nccn.org/professionals/physician_gls/
- Palmore E (2015) Ageism comes of age. *The Journals of Gerontology: Series B* **70**, 873–875. <https://doi.org/10.1093/geronb/gbv079>
- Saracino R, Nelson CJ, and Roth AJ. (2017) Communication with cognitively impaired older adults and their families. In Korc-Grodzicki B and Tew WP (eds), *Handbook of Geriatric Oncology*. New York: Springer, pp. 265–272.
- Schroyen S, Adam S, Jerusalem G, et al. (2014) Ageism and its clinical impact in oncogeriatrics: State of knowledge and therapeutic leads. *Clinical Interventions in Aging* **10**, 117–125. doi:10.2147/CIA.S70942
- Smith BD, Smith GL, Hurria A, et al. (2009) Future of cancer incidence in the United States: Burdens upon an aging, changing nation. *Journal of Clinical Oncology* **27**, 2758–2765. doi:10.1200/JCO.2008.20.8983
- Thomas DC, Leipzig RM, Smith LG, et al. (2003) Improving geriatrics training in internal medicine residency programs: Best practices and sustainable solutions. *Annals of Internal Medicine* **139**, 628–634. doi:10.7326/0003-4819-139-7-200310070-00037
- Weiss BD and Fain MJ (2009) Geriatric education for the physicians of tomorrow. *Archives of Gerontology and Geriatrics* **49**(Suppl 2), S17–S20. doi:10.1016/S0167-4943(09)70007-X
- Wilkins KM, Lund BC, McAdams JD, et al. (2009) Clinical utility of the Hopkins Competency Assessment Test on an inpatient geropsychiatry unit. *American Journal of Alzheimers Disease and Other Dementias* **24**, 34–39. doi:10.1177/1533317508326374