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Patient-Physician-Relationship in Cancer Care – Relevance and Ambivalences as Perceived by Oncologists

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Abstract A major function of patient-physician-communication is building a trustful relationship and a therapeutic alliance between patient and physician. However, building trustful relationships to patients is subject to ambivalences. There are role expectations including affective neutrality, that stand in contrast to this function. Moreover, translation into every day routine is constricted by lack of time or lack of tools, and building a trustful relationship with the patient is a personal challenge. This qualitative study based on semi-structured interviews with oncologists was conducted to explore oncologists' perceptions and experiences of the relevance of trusting relationships to their patients and to examine sources of ambivalences. The results show that a trusting patient-physician-relationship is for oncologists an important prerequisite for successful cancer treatment in terms of open communication, adjustment of treatment to patients' needs, compliance, control of adverse events, activation of patient's resources, patients' treatment confidence, reduction of patients' anxiety, meeting family and caregiver needs and patients' coping efforts. Supporting critically ill patients can be both enriching and stressful. Being rejected by patients in case the therapy does not work was experienced as painful by some oncologists. There is a need for support for oncologists to establish trustful patient-physician-relationships during their patients' cancer journey. The support will have to address contextual factors, communication skills and the attitude needed to face the personal challenge of building trustful patient-physician-relationships. It should provide a protective environment to reflect on one's own fears and challenges in building relationships with patients.

Keywords trust, relationship, therapeutic alliance, oncology, ambivalences

Background

The relationship between patient and physician is at the heart of medicine. A major function of patient-physician-communication is building a trustful relationship and therapeutic alliance between patient and physician (Haes & Bensing 2009: 287–294). Following Weber (1921), social behavior includes meaningful behavior of actors that is mutually related. A social relationship is built by social behavior of actors with the actor expecting a certain attitude of his counterpart and orientating his action towards this expectation (Weber 1921). The patient-physician-relationship is a particular form of social relationship. It is characterized by a fundamental asymmetry in terms of expert authority, defining authority, and management authority: The physician knows symptoms, diagnosis, prognosis, and treatment plans – the patient is the layperson. The physician has the power to define, diagnose, classify, differentiate between healthy and ill, or decide about sick-leave. And the physician determines care structures and processes, appointments and diagnostic procedures, and treatment recommendations (Siegrist 2005). Moreover, the patient-physician-relationship is characterized by involuntariness in most encounters which is especially true for the physician perspective (Begenau, Schubert & Vogt 2010: 7–33).

A conceptual model to reduce this asymmetry and its consequences is patient-centred care. In oncology, where patients experience physical burden, emotional distress, anxiety, depression, or decisional uncertainty during the cancer journey, patient-centred care is of particular importance. Patient-centred care has been defined as "respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (Committee

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on Quality of Health Care in America, Institute of Medicine 2001). Patient-centred care respects the patient as a unique person, emphasizes communication and information, involves and empowers the patient, promotes a partnership between patient and provider, and gives emotional support (Zill, Scholl, Härter & Dirmaier 2015). According to the integrative model of patient-centeredness (Scholl, Zill, Härter & Dirmaier 2014) a central principle of patient-centeredness is a patient-physician-relationship characterized by trust and caring. Such a relationship then allows central activities of patient-centred care, i.e. patient information, patient involvement in care, involvement of family and friends, patient empowerment, and emotional support (Scholl, Zill, Härter & Dirmaier 2014). Following Scholl, Zill, Härter & Dirmaier (2014) enabling factors for patient-centred care are communication skills, the integration of medical and non-medical care, access to care, continuity of care, teamwork and teambuilding.

Ambivalences

The physicians' decision and the process of building and maintaining trustful relationships with cancer patients (Hillen, deHaes & Smets 2011: 227-41) is subject to ambivalences. At least three sources of ambivalences can be assumed: First, there are specific role expectations the society has towards the physician. The physician's role includes technical competence, universalism, affective neutrality, functional specificity, and collectivity-orientation (Parsons 1951). Being affectively neutral implies that the physician treats patients equally and does not become emotionally aroused during professional activities. Second, the translation into every day routine is constricted by obstacles such as lack of time to explain complex information, lack of tools to facilitate treatment planning, or insensitivity to patients' needs (Balogh, Ganz, Murphy, Nass, Ferrell & Stovall 2011: 1800–1805). Prior research within the WIN ON study based on the interview data revealed that a stressed oncologist has difficulties in showing empathy and patient-centredness (Gross, Ernstmann, Jung, Karbach, Ansmann, Gloede, Pfaff, Wirtz, Baumann, Schmitz, Osburg & Neumann 2014: 594–606). Third, building a partnership with the patient in oncology is a personal challenge (Maguire 1985: 1711–1713; 1999: 2058–2065). It has been shown that oncologists find patient loss particularly difficult for relational reasons, e.g. in instances where they feel close to patients and their families, when they have long-term patients, and when deaths are unexpected (Granek, Krzyzanowska, Tozer & Mazzotta 2012a: 1254–1260; Granek, Mazzotta, Tozer & Krzyzanowska 2012b: 2627–2632; Shanafelt, Adjei & Meyskens 2003: 2616–2619). Oncologists find sharing a bad prognosis, especially when they care deeply for their patients, to be stressful (Abernethy, Campbell & Pentz 2019: 1163-1165). These findings might explain that oncologists' professional strategies to cope with patients' death include focusing on work, withdrawing from patients at end of life, and compartmentalization, i.e. drawing boundaries between home and work life (Granek, Ariad, Shapira, Bar-Sela & Ben-David 2016: 4219–4227).

Theory and empirical evidence

Why should oncologists bear this personal and professional challenge of building a trustful relationship with their patients? Is there a goal that helps overcoming the ambivalences? Is there evidence that communicating well with patients makes any difference to health outcomes? The "effect model of empathic communication in the clinical encounter" (Neumann, Wirtz, Bollschweiler, Mercer, Warm, Wolf & Pfaff 2007: 63–75) explains how empathy can lead to improved patient outcomes. As consolidation and extension of former models, this model describes an affective pathway of empathic communication leading to patients' emotion of feeling understood (Squier 1990: 325–339; Suchman, Markakis, Beckman & Frankel 1997: 678–682), and a cognitive pathway of empathic communication (Squier 1990: 325–339). The cognitive pathway postulates that patients, when experiencing physician's empathy, are supposed to tell more about their symptoms and concerns, facilitating the physician to collect more detailed medical and psychosocial information. This in turn leads to a diagnosis that is more accurate and helps the physician to understand and respond to the individual needs of the patients which may result in a better com-

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munication with regard to its informative, participative, and educative components (Neumann, Wirtz, Bollschweiler, Mercer, Warm, Wolf & Pfaff 2007: 63–75) and to stronger adherence to treatment regimens and preventative strategies (Squier 1990: 325–339). Thus, patients may experience improved long-term health outcomes.

When looking at empirical evidence, many studies have revealed associations between a caring and educating communication, trust in physician, control of treatment and side effects, patients' satisfaction, perceived quality of care, reduced hopelessness, distress, and health outcomes (Coulehan, Platt, Egener, Frankel, Lin, Lown & Salazar 2001: 221–227; Ernstmann, Weissbach, Herden, Winter & Ansmann 2016: 396–405; Ernstmann, Herden, Weissbach, Karger, Hower & Ansmann 2019: 2114–2121; Farin & Nagl 2013: 283–294; Franco, Joseph, Fei & Bickell 2009; Hinnen, Pool, Holwerda, Sprangers, Sanderman & Hagedoorn 2014; Lin, Chao, Bickell & Wisnivesky 2016: 976–989; Maly, Liu, Liang & Ganz 2015: 916–926; Robinson, Hoover, Venetis, Kearney & Street 2013: 351–358; Squier 1990: 325–339; Stewart 1995: 1423–1433). However, so far little is known as to how oncologists judge the importance of a trusting patient-physician-relationship. Do they believe that the partnership with their patients has the potential to impact health outcomes in a discipline dominated by seriously, chronically or terminally ill patients and invasive therapies such as surgical treatment, chemotherapy and radiation? Do they perceive conflicting aims, role conflicts or ambivalences in establishing trustful patient-physician-relationships? So far, there is one qualitative study addressing parts of the issues raised, showing that oncologists have a limited understanding of the value, implications, and motivation for improving patient-centred care in general (Nguyen, Bauman, Watling & Hahn 2017: 213–219).

Aims and Methods

The present qualitative study was conducted 1) to improve our knowledge of oncologists' perceptions and experiences of the relevance of a trusting relationship between cancer patients and physicians for treatment process and patients' outcomes and 2) to examine sources of ambivalences in establishing a trustful patient-physician-relationship in cancer care.

The following analysis is part of the WIN ON study (Working conditions in oncology) (DFG Grant #: PF 407/4-1, WI 3210/5-1). WIN ON is an interdisciplinary prospective multicenter study examining the effects of working conditions of private practice oncologists on patient-physician-communication and patient reported outcomes. The ethics review committee of the University hospital of Cologne approved the research protocol. All participating physicians gave written informed consent to be interviewed or surveyed for the study.

The qualitative study part included semi-structured interviews with 11 oncologists (7 male, 4 female; 42-59 years of age; 1-18 years in private practice) selected by purposeful sampling according to sex, size and type of private practice and years in private practice. The interviews were conducted by two trained interviewers. The oncologists were recruited as members of the Professional Association of Office-based Hematologists and Oncologists in Germany (BNHO) via mailing. The interviews took place in oncologists' offices and had a mean duration of 60 minutes. The semi-structured questionnaire covered aspects of work organization, working conditions and patient-physician-communication in oncology practices. The interviews were audiotaped and transcribed according to transcription guidelines (Fuss & Karbach 2014). The authors analyzed the interviews by combining inductive and deductive coding and categorization techniques of content analysis for research aim 1 (Mayring 2010: 601–613): Deductive coding was based on the interview guiding questions as a priori codes. Inductive coding has expanded the coding tree by adding new aspects and allowing to reduce the material to new categories. For research aim 2 both content analysis and contrasting thematic coding techniques (Flick 2010) were used. The sources of ambivalence were deductively coded based on the a priori assumptions. Contrasting the codes then helped to gain a deeper understanding of the positive and negative elements of each source of ambivalence.

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Results

1.) Relevance of the patient-physician-relationship in cancer care

General meaning and quality of the patient-physician relationship

The interviewed oncologists unanimously felt that the patient-physician relationship is of great significance in oncology. Feeling comfortable in the practice and having trust in the physician and the physician's therapeutic decisions were seen as an important basis and a main prerequisite for such a therapeutic alliance. Trust was considered fundamental to the patient-physician relationship – if there is distrust between the physician and the patient, the relationship is fundamentally destroyed. While a loss of trust can lead a patient to change the physician, the oncologists also believed that it is possible to regain that trust during treatment through conversations with the patient and therapeutic successes. All of the oncologists talked about trust in one direction only – the trust of the patient in the treating oncologist. Patients' trust in oncologists and their treatment is the goal of oncologists. The impact that physicians' trust in their patients has in the course of treatment was not mentioned during the interviews.

The first consultation with a physician was primarily seen as the cornerstone for a trusting patient-physician relationship since it determines whether the patient can develop trust in the physician. According to the majority of the oncologists, it is of vital importance that physicians take time to build such trust in their patients, provide them with sufficient information and plan therapy together with them. Several of the oncologists felt that the patient-physician relationship is particularly important in oncology. Unlike in other medical specialties, in oncology patients find themselves at "crossroads in their lives," a time when they are faced with existential questions and decisions. Trust is regarded as essential for getting patients to accept therapy suggestions and put themselves in the hands of their oncologists. It is therefore not seen as something voluntary since the patients have no other choice.

> IP: Um, because I think that you do have to have trust in order to let yourself be treated the way patients here let themselves be treated. I think that in this case though, the patients are often at a, uh, crossroads in their lives—mm, not like with therapy for blood pressure or blood sugar—but a situation where they have to go into it with even more trust and, uh, also just have to have trust in the ones doing it and somehow tell themselves, 'these are the right ones for me right now.' They're making the right decisions for me or the right decisions with me.

In addition to the patient-physician relationship, some physicians emphasized the importance of the interprofessional practice team. These physicians placed less value on the personal relationship with the oncologist and more value on the overall atmosphere in the practice, which they defined as the sum of the personal relationships with the reception staff, nursing staff and oncologists. Conversations between a patient and the practice staff after the patient's first consultation with the physician, for example, could make up for the consultation not going well and instill trust in the patient.

> I: In your opinion, how important really is the personal relationship between you and your patients for the success of treatment [...]?
>
> IP: Very, very important. Although, um, I wouldn't necessarily say the personal relationship with just ME, but the relationship with WHOMEVER the patient encounters. (I: mm-hmm) That includes me, the receptionists, and the nurses. (I: okay) I think it's extremely important.

However, not all of the oncologists found the atmosphere in a practice to be of key importance. One oncologist made a clear distinction between the importance of the personal conversation between a patient and a physician and the influence of the practice team. To him, it is the patient-physician conversation that determines whether the patient will develop trust in the physician. If the conversation goes well, even a rather poor practice atmosphere can be tolerated. This oncologist also considered practice facilities and decor to be of secondary importance.

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IP: Even unfriendly nurses in the reception area, diagnostic shortcomings, etc. can all be put up with if the, if it works, if the conversation goes well. […] So, that's the only way, it's only through the conversation that trust can be gained (I: mm-hmm), that it can develop. Other things then, like the way things look here, whether we still have old wallpaper or whether the rose bush, uh, the bouquet of roses has wilted, aren't important, you know? (I: mm-hmm) It's the: conversation that is the most important.

Most of the oncologists described their relationship with their patients as being a close and stable relationship, which some of the oncologists believe can definitely come to take on a friendship-like nature. When caring for their patients, they often take the patients' environment into consideration. For some oncologists, providing patients with care and support beyond the actual treatment of cancer (sometimes over many years) can and should result in the development of a new form of bond where the boundaries between a professional and personal relationship become blurred.

Effects on patient-physician communication

Having trust in their oncologists encourages patients to ask critical questions about therapy and to express their needs and how they see things. According to some of the oncologists interviewed, a personal relationship must be present in order for the patient to feel confident enough to point out errors or to ask questions about anything that is unclear. Only then the patient can serve as a "second set of eyes" during care. The personal relationship between a patient and a physician is therefore considered a resource which helps to better adjust therapy to the individual patient.

IP: […] The patient should have the feeling […], mm, should be able to say, uh, something like 'Doctor is it possible something's been forgotten?' So, I need the patient as a second set of eyes [uh-huh okay] and he has to have the feeling that that's also, uh, what I would like from him.

IP: But, the question is whether I always ask: 'So, how are you doing?' and 'Are you doing okay?' [mm-hmm] or 'Do you have a fever?' mm, or [I: okay] so I can then see if all complications are now out of the way and I can now administer chemo. [I: mm-hmm yeah] That's why it's also good to, um, to get to know the patient personally. He knows he can tell me and, uh, I'll look into it, which is also good for me because then I can take care of it.

If, however, the relationship between a patient and an oncologist is a poor one, there is a great risk that messages will go unnoticed or will be misunderstood.

IP: When the personal relationship (.) is poor—it's possible, [I: mm-hmm] for a physician and patient not to be a good fit at all—um, I think that that threatens the success of treatment [uh-huh] because then, mm, messages don't get through: or go unnoticed.

Effects on compliance and long-term treatment

Some of the interviewed oncologists stressed how important a stable and personal patient-physician relationship is for the long-term treatment and follow-up care of their patients. Having a close relationship with their patients leads the patients to go in for regular check-ups, which make it possible to provide them with optimum care and support. One perceived benefit of a close relationship with the oncologist is that it can also lead the oncologist to take the role of the primary care physician in providing follow-up care or to supplement the follow-up care provided by the primary care physician with specialist care. This was considered particularly beneficial since an oncologist may be more likely than a primary care practitioner to recognize cancer-specific symptoms indicating relapse or deterioration in a patient's condition and can take countermeasures.

I: […] if the relationship is a good one [yes] yes.

IP: Then they come here. The thing is that these special diseases aren't monitored as well by primary care physicians. [I: okay, mm-hmm] In other words, when these patients have a problem, I think that we detect it a bit earlier than primary care physicians do (.) yeah. [okay] Although we always discuss it with the primary care physicians first to see whether they want to send the patients to us [I: mm-hmm] when they're in a chronic stage.

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A close patient-physician relationship was also seen as beneficial for patient compliance with acute therapy. If the patient tells the physician about side effects and symptoms they are experiencing as a result of chemotherapy, the physician can then better adjust the therapy based on the side effects experienced by the individual patient. Moreover, when there is a close relationship, the physician can somewhat explain these side effects and motivate their patients to continue with therapy despite the side effects by getting them to focus on relief or healing. This then results in better compliance, which also increases the chances that therapy will be more successful.

> IP: [...] if, um, we spot side effects early enough, counteract them and EXPLAIN WHY, why they should stick with it [I: uh-huh], why it's worth it to take this or that measure to counteract the side effects, then there is MUCH better compliance, MUCH better adherence and, OF COURSE, greater therapy success.

Effects on coping with the disease

A personal patient-physician relationship is considered to have numerous positive effects on the ability to cope with disease. Although the oncologists interviewed did not explicitly talk about the coping of cancer patients, it seems to be a latent construct which can be found in their statements and the positive experiences they have had in their practices. One example of coping found in the oncologists' statements is the activation of personal resources. A personal patient-physician relationship can help patients get back the strength they need to reestablish social contacts or to start doing things with renewed interest. Another example of coping can be found in a discussion of patient fears. As one oncologist expressed, he hopes that a personal relationship will also help alleviate fears that may be crippling and inhibiting patients. His statement primarily refers to patients with chronic diseases and includes the hope that the patients will be empowered to make the most of the time they have left.

> I: And, um, what effect do you think your relationship with the patient has [...]?
>
> IP: Well, what I hope is that he will get something out of the time we dedicate to him during therapy [mm-hmm], that he'll stop sitting there like a deer caught in the headlights and say, 'Okay, I have a bit of time now and a bit of strength. I'm either going to go, um, visit relatives or go to the opera' [...], that he'll keep living.

Once a personal and trusting relationship between the patient and physician has been established, it is then possible to discuss issues involving death and grief in the family. According to some of the oncologists, they can come to serve as a mediator between patients and their family members or as an adviser. The relationship also allows physicians to approach family members about existential issues. A long-term relationship can lead the oncologist to be consulted on private or spiritual matters as well. Such a stable relationship can also help with the acceptance of death and coming to terms with having lost the battle against cancer. Although a close relationship cannot be formed with every patient, if it is, some of the oncologists believe that it can lead to a blurring of professional and role boundaries.

> IP: [...] after a certain amount of time of trusting, they actually start asking questions that they feel moved to ask. They just let them out and that's what makes the difference, so to say. All of a sudden, they actually become their own life coaches [I: uh-huh] and I would say that we physicians are sometimes something like modern-day priests.

Effects on patient-reported outcomes

In terms of the effects a close patient-physician relationship has on the success of treatment, the oncologists credited the relationship as having a positive impact on patient satisfaction, well-being and quality of life. Interestingly, however, several of them made a distinction between treatment success and psychological (or subjective) outcomes. Whereas the concept of quality of life, for example, was considered to be limited to patients' psychological state, the construct of treatment success tended to be associated with physical parameters, especially survival time. These oncologists tended to deny that there is a connection between the patient-physician relationship and treatment success.

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I: In your opinion, how important really is the personal relationship between you and your patients for the success of treatment?

IP: For TREATMENT SUCCESS, mm, I don't think it's that: important. [I: uh-huh] For patient SATISFACTION [I: uh-huh] for their QUALITY OF LIFE, it's EXTREMELY important.

Some of the other oncologists, however, did consider a personal patient-physician relationship to affect the physical outcome of oncological treatment by helping patients handle the side effects to improve the course and result of treatment.

IP: Whether the tumor becomes five centimeters bigger or smaller in response to the chemotherapy probably can't be influenced by the conversation. But, uh, as far as how the patient feels, it's very important; it's also very important for how he gets through the many side effects of the therapy.

IP: [...] it has a SUBSTANTIAL impact, mm, on how patients handle the side effects [I: uh-huh]. THAT'S a big thing and then considering, mm, if you consider that as part of the outcome, uh [I: mm-hmm], the outcome of treatment, then, of course, it is of GREAT importance.

The significance of patients' motivation to continue with therapy was also mentioned during the interviews, with a connection being drawn between the motivation of the physician and the practice team on one side and the motivation of the patients on the other. If the physician and practice team demonstrate a high motivation to treat the patient, this motivation can then impact the patient's own confidence and motivation, making it possible to continue with therapy longer. In a best-case scenario, this can then have an impact on the individual survival rates of patients.

IP: [...] despite the fact that they have a chronic disease, how long patients with metastasized cancer live how long they SURVIVE depends greatly on how much motivation WE have [I: mm-hmm] and how much we are also able to communicate to patients [I: mm-hmm] that life keeps on going [I: mm-hmm], a bit more, and a bit more despite their disease and that has an impact on patient survival times.

2.) Sources of ambivalences

Ambivalences in building partnerships with their patients are not being reflected upon by most of the oncologists though possible sources of ambivalences are often mentioned. Organizational factors, e.g. working hours, time pressure, documentation or interruptions, were seen as obstacles for a patient-centred communication; however, oncologists did not attribute these factors to the quality of their patient-physician-relationships. They admitted disturbing effects of organizational factors on the quality of the encounters though the quality of the patient-physician-relationship was not associated with these factors.

The thematic coding revealed that for those oncologists who integrate death and dying into their daily practice, the patient-physician-relationship is a central aspect of their values and routines and might even get closer in the last period of patients' lives.

IP: [...] We have a glass with petals, [...] when one of our patients dies, um, a yellow rose is dried. [...] Of course, there are already many who have been cared for very intensively over the years and often with several contacts a week at the end. Um, that is not just demanding [...] You get a lot back. So many patients give you the feeling, 'It was good what you did.' It's nice.

The same oncologist states later:

IP: There is this way downhill. And yet there is a good relationship and a relationship in which, wherever I notice it, they rely on us to do what is possible [...], um, where there really is a basis of trust. And over a long time there often grows a personal relationship, where you just laughed a lot with each other, even in spite of difficult situations, or just some crap that you have gone through together, um, where really [..]a real relationship arises.

Another oncologist who lost her husband to cancer even shares her private experience with cancer and dying with her patients:

I: [...] How do you deal with the issues of emotional stress or dying and death if you are caring for a palliative patient?

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> IP: Of course, I'm trying to talk to the patient about it. […]. Then I sometimes say to the patients […] 'When you get up there, tell my husband, he can get in touch with me'.

Another oncologist perceives close relationships to her patients, or "being involved", as a burden. Later in the interview when asked for the meaning of the patient-physician-relationship, she depicts the following situations, indicating that for her the quality of the relationship – or the potential of the relationship to cause inconvenience – is associated with the hope for cure.

> IP: […] They come once a quarter or half a year and then, um, I am told half a life and what has happened in the last six months [hm] and uh they are so happy and satisfied when they are back. Even if it's just a routine check, they don't want to stop coming here. So, these are very, very strong ties [I: hm] yes. And that's the positive thing. It's not just seriously ill patients with whom we have to talk about dying now, but we also have a very large number of chronic patients [hm] who are doing well. We can care for them for many years and that is highly satisfactory […].

> IP: […] They [physicians in cancer centers] do everything possible and then you can no longer help him and then he is sent to the oncologist. Now he should go on [I: hmhm]. And then, these relationships are extremely difficult [I: hm okay], you don't have much that you can offer as treatment options.

Another oncologist reports similar experiences of relationships being associated with the illness trajectory. Here, patients are described as distancing from physicians when their hope for cure is not fulfilled.

> IP: […]There are sometimes alienations. So, one starts hopefully therapies and they do NOT lead to the desired outcomes, […] then it comes to depreciations because we can't make it, [I: mhm] also times of disappointment, unmet expectations, [I: mhm] blame, depreciations, that also happens.

Some oncologists report strategies of professional distance and intellectualization as coping mechanism in situations when they are affected by the patient's fate.

> IP: […] This is, um, that is, this is more difficult. Breaking bad news is difficult, when there are no treatment options at all. It is one of the most difficult things.

> IP: […] You do learn how to abstract things, how to ignore them. There are always individual, individual fates that of course affect you and touch you, but not in such a way that this, um, that this bothers you at the end of the day, no.

One oncologist describes ambivalences in terms of religious doubts and in terms of putting everything into perspective in his personal life as consequence of close relationships in late stage and end-of-life care.

> IP: […] Working in oncology, especially in the continuous care of patients […] until their death, of course, has a significant impact on our own lives. [I: mhm] You can't avoid thinking about the meaning of life and […] draw your own conclusions from it. [I: mhm] So oncology and religiosity are […] a very difficult field. [I: mhm] I know […] that uh, uh, it is very difficult as an oncologist not to […] develop doubts about your own religious belief. [I: mhm] Um, for me personally, that's what happened.

> IP: […] It is a tremendous enrichment if you understand early what is important in life. Um, it is a disadvantage because sometimes you can no longer get upset in real life. [I: mhm] Yes, you can no longer get upset about your accountings […] because it is actually not so important after all. That's a typical discrepancy yes. [I: yes] […] I mostly experience it as positive. […]

His positive conclusion in terms of personal and professional growth is reflected in the following quote:

> IP: […] Establishing a relationship, […] keeping the emotionality [I: mhm] […], maybe that is what makes the work really interesting after so many years. If you pass the master's exam [I: mhm] and suddenly can open the gate to a completely different level.

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Summary

The qualitative analysis suggests that a trusting patient-physician-relationship is an important aspect in cancer care for oncologists. Trusting the physician and the physician's therapeutic decisions is seen as an important basis for a therapeutic alliance by the oncologists. However, some oncologists acknowledge the importance of themselves as central person more than others who emphasize the importance of a team of physicians or a multiprofessional team in private practice. An impact of a trusting patient-physician-relationship on treatment success is rather associated with psychological adjustment than with clinical outcomes, e.g. morbidity or mortality. Some oncologists perceive positive effects of a trusting patient-physician-relationship on treatment outcomes following the described cognitive pathway of empathic communication. For oncologists, close relationships to their patients might be a burden as well as a satisfying aspect of their work.

Discussion

The aim of this study was to explore the oncologists' perspective on the relevance of the patient-physician-relationship and sources of ambivalences in establishing trustful patient-physician-relationships in cancer care. The interviews are rich; we were able to discuss the topic of patient-physician-relationship with all interviewees. The oncologists have different approaches to the subject of relationships, which they are aware of or became aware of during the conversation. These approaches are describable and stable for them and prove functional for their respective medical practices despite occasional ambivalences. The findings show that for oncologists, a trusting patient-physician-relationship is an important prerequisite for successful cancer treatment in terms of open communication, adjustment of treatment to patients' needs, compliance, control of adverse events, activation of patient's resources, patients' treatment confidence, reduction of patients' anxiety, meeting family and caregiver needs and patients' coping efforts. These positive effects are attributed to the oncologists themselves, to a team of oncologists, or to a multiprofessional team in private practice.

Some oncologists consider a personal patient-physician relationship to affect the treatment outcome whereas others feel doubtful about such an association. Different opinions might partly arise from divergent definitions of the concept of treatment or treatment outcome, from quality of life to physical parameters or survival. Some of the variance might result from different experiences with the effects of a partnership or due to a different willingness to build close relationships. The willingness might depend upon aspects of physicians' personality, bonding styles, communication styles, or communication skills. These associations cannot be examined in our data and could be subject to future studies. Another explanation for doubts concerning the association between partnership and treatment outcomes might be the fact that some oncologists are not aware of the cognitive pathway linking communication to treatment outcome. This would be in line with the findings of Nguyen, Bauman, Watling & Hahn (2017: 213–219), who reported a limited understanding of the value, implications, and motivation for patient-centred care in oncologists. The methodologic approach of our study does not allow to test these assumptions; the interviews might be biased by social desirability. The affective pathway of empathic communication leading to patients' emotion of feeling understood is recognized by the oncologists. However, the pathway postulating that patients are supposed to tell more about their symptoms and concerns, facilitating the physician to collect more detailed information which in turn leads to a diagnosis that is more accurate and helps the physician to respond to the individual needs of the patients, is only partially realized by the oncologists. Remarkably enough, some oncologists describe different pathways in terms of indirect effects of trust, but direct psycho-neuroimmunological effects of trust such as anxiolytic or antidepressant effects of oxytocin are not considered at all. However, the interview guideline did not include any specific follow-up questions on this topic, which might partly explain this finding.

The major impact of the health status and the course of treatment becomes evident in several re-

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spects. A deterioration of health condition or the possibility of cancer treatment not working has a significant impact, both for the trusting relationship from the patient's perspective and for the burden of a trustful therapeutic alliance for the oncologists. Suspicion and mistrust could arise, and oncologists might distance themselves for their protection. Most oncologists feel more comfortable in close relationships as long as the therapy works, as long as the "arrangement of hope" (Hermann 2005) holds.

Supporting critically ill patients can be both enriching and stressful for some respondents. The effects on one's own life are substantial and are sometimes perceived as ambivalences. Life perspectives change, even religious doubts may arise. The principle of partnership and a therapeutic alliance is perceived as both fascinating and strenuous and might lead to personal maturation. Being rejected by patients in case the therapy does not work could be a painful experience for oncologists in close relationships having to process their unfulfilled expectations as well as the frustration of their patient.

The role expectation of affective neutrality was not mentioned in the interviews; those oncologists placing more emphasis on relationship building even reported dyadic expectations of building a therapeutic alliance with the cancer as enemy both patient and physician are fighting against. Organizational aspects were not regarded as barriers for a trustful patient-physician-relationship; however, contextual factors in private practice were perceived as disturbing factors during the medical encounter. Hence, the consequences of a disturbed communication for patient-physician-relationship (Gross, Ernstmann, Jung, Karbach, Ansmann, Gloede, Pfaff, Wirtz, Baumann, Schmitz, Osburg & Neumann 2014: 594–606) are ignored or perceived as reducible by oncologists' communication skills.

Considering the integrative model of patient-centeredness (Scholl, Zill, Härter & Dirmaier 2014) our results underline oncologists' recognition of a trustful and caring patient-physician-relationship as central principle of patient-centeredness. Aspects of communication, teamwork and continuity of care are mentioned in the context of patient-centred care. Whether these aspects are perceived as enabling or associated factors of patient-centeredness remains unclear. Patient information, patient involvement in care, patient empowerment in terms of supporting self-management and emotional support are seen as important activities and as closely related to trustful patient-physician-relationships. Active involvement of and support for the patient's relatives and friends tend to be less of a topic.

Limitations

There are limitations to our research that should be considered when interpreting the results. Due to the exploratory character of our study, our results should be considered indicatory. This is one of the first studies qualitatively examining the oncologists' perspective on the relevance of patient-physician-relationships. The interview sample size is small; however, maximum variation of the sampling criteria was achieved. Nevertheless, there may be self-selection bias due to the interviewees' interest in the study. The interviewees' responses regarding the relevance and ambivalences of relationships to their patients might be subject to self-consistency as well a self-serving and belief bias. Our results suggest different patterns or types of relationship preferences. We are not able to build such types based on our data collected to explore all aspects of the relevance of trustful relationships and sources of ambivalence in our sample. Type-building should be subject to future research.

Implications

Contemporary oncology practice acknowledges more and more the importance of partnering with the patient and family in dealing with the illness (Baile & Aaron 2005: 331–335). Even renewed interest in promoting compassion as desired professional attitude did arise (Cameron, Mazer, DeLuca, Mohile & Epstein 2015: 1672–1685; Gelhaus 2012: 397–410). However, when thinking about patient-physician-relationships in oncology, differences between acute care in cancer centers and follow-up care in private practices of oncologists have to be considered. Physicians in hospitals will in most cases not have the chance to establish and maintain a close relationship to their cancer patients during a short hospital stay

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of a few days. In large cancer centers with multiprofessional care teams cancer patients might not even know who is their primary contact person. However, in long term follow up care, the relationship is an important resource and central aspect of the quality of care. In private practice oncology, the oncologist is the central contact person and expert, and – following our results – might even be consulted on private or spiritual matters. This seems particularly relevant since patients are offered less psycho-oncological or psychosocial support from other sources in long-term and follow-up treatment than in cancer centers during acute care.

What kind of support do oncologists need to fulfill this important task? The support will have to address contextual factors as well as the communication skills and the attitude needed to establish trustful patient-physician-relationships. However, the keys for establishing trusting relationships, e.g. the role of authenticity, remain to be identified (Stiefel & Bourquin 2019). Earlier analyses of the WIN ON survey and interview data has shown that the working conditions play a central role – emotionally exhausted oncologists might not have the personal and organizational resources to build and maintain close relationships to their patients (Gross, Ernstmann, Jung, Karbach, Ansmann, Gloede, Pfaff, Wirtz, Baumann, Schmitz, Osburg & Neumann 2014: 594–606 ; Nitzsche, Neumann, Gross, Ansmann, Pfaff, Baumann, Wirtz, Schmitz & Ernstmann 2017: 462–473). The same effect has been shown in cancer centers (Ansmann, Wirtz, Kowalski, Pfaff, Visser & Ernstmann 2014: 352–360).

Existing communication skills trainings address aspects of communication such as breaking bad news and discussing unanticipated adverse events, discussing prognosis, reaching a shared treatment decision, responding to difficult emotions, coping with survivorship, running a family meeting, and transitioning to palliative care and end of life (Kissane, Bylund, Banerjee, Bialer, Levin, Maloney & D'Agostino 2012: 1242–1247; Merckaert, Libert & Razavi 2005: 319–330); however, aspects of building and maintaining a trustful alliance to cancer patients over a long period are rarely addressed. Moreover, existent trainings rather address skills and techniques instead of values or reflexivity (Stiefel & Bourquin 2016: 1660–1663). Private practice oncologists are often working in group practice, but are not involved in a large multiprofessional care team in their daily routine as it is standard practice in cancer centers. There might be a need to make use of Balint groups, also in private practice oncology (Bar-Sela, Lulav-Grinwald & Mitnik 2012: 786–789), where defence mechanisms, emotional exhaustion, loss, grief, disappointment or anxiety could be addressed. Even the offer of psycho-oncological support for all medical professions who are dealing with cancer patients (Tanriverdi 2013: 530) or trainings addressing death competence (Draper 2019: 266–274) have been recently discussed. An interprofessional discussion of support needs of oncologists working in private practice and joint efforts to develop targeted interventions addressing individual and contextual factors of individual relationship-building needs might be helpful in the future.

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