

# Doctor-Patient Communication Improves Treatment Acceptance in Cancer

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Patients diagnosed with serious illnesses, particularly cancer, frequently experience self-blame, which can impede their acceptance of necessary medical treatments. A presentation at ASCO 2026 highlighted how targeted communication strategies by clinicians can mitigate this barrier, leading to improved treatment adherence.

## KEY TAKEAWAYS

- **The Pivot:** Addressing patient self-blame directly through empathetic communication improves treatment acceptance.
- **The Data:** Patients whose self-blame was addressed by a clinician showed a 28% higher rate of treatment acceptance ( $p=0.003$ ).
- **The Action:** Clinicians should integrate specific communication techniques to identify and counter patient self-blame during treatment discussions.

The psychological burden of a cancer diagnosis often extends beyond the physical symptoms, with many patients internalising blame for their condition. This self-blame can manifest as resistance to treatment, a reluctance to engage with medical advice, or a general sense of hopelessness, all of which compromise therapeutic outcomes.<sup>1</sup> Understanding and addressing this psychological barrier is critical for optimising patient care and ensuring that individuals receive the full benefit of available interventions.<sup>2</sup>

Globally, cancer incidence continues to rise, making effective patient engagement in treatment paramount. The emotional distress associated with a cancer diagnosis is a well-documented phenomenon, with studies indicating that up to 40% of cancer patients experience significant psychological distress, including anxiety and depression. This distress can be exacerbated by feelings of guilt or responsibility for their illness, which can stem from various sources, including perceived lifestyle choices, genetic predispositions, or even spiritual beliefs. Such internalised blame creates a significant obstacle to therapeutic adherence and overall well-being.<sup>1</sup>

## The Clinical Intervention

A presentation at the American Society of Clinical Oncology (ASCO) 2026 annual meeting detailed an observational study examining the impact of clinician communication on patient self-blame and subsequent treatment acceptance. The study involved 450 adult patients newly diagnosed with various solid tumours across three oncology centres. Patients were randomised into two groups: an intervention group (N=225) where clinicians received specific training in empathetic communication techniques focused on identifying and addressing patient self-blame, and a control group

(N=225) where clinicians provided standard care.<sup>3</sup>

The patient population included individuals diagnosed with common solid tumours such as breast, colorectal, lung, and prostate cancer, ensuring a representative sample of oncology patients. Eligibility criteria included being over 18 years of age, having a new diagnosis of a solid tumour, and being deemed medically fit to undergo standard cancer treatment. Patients with pre-existing severe psychiatric conditions or cognitive impairment that would impede communication were excluded. The randomisation process was stratified by cancer type and stage to minimise potential confounding factors between the groups.<sup>3</sup>

Clinicians in the intervention group were trained to actively listen for expressions of guilt, regret, or responsibility for their illness. They were instructed to validate the patient's feelings while gently reframing the narrative, emphasising the multifactorial nature of disease development and the patient's lack of culpability. This involved using phrases such as, "Many factors contribute to cancer, and it's never anyone's fault," and "Your focus now should be on healing, not on what might have been." The primary endpoint was the rate of initial treatment acceptance within four weeks of diagnosis. Secondary endpoints included patient-reported distress levels and adherence to the first cycle of treatment.<sup>3</sup>

## Key Findings

The study demonstrated a statistically significant difference in treatment acceptance rates between the two groups. In the intervention group, 189 out of 225 patients (84%) accepted their recommended treatment within the four-week period, compared to 126 out of 225 patients (56%) in the control group. This represents a 28% absolute increase in treatment acceptance ( $P=0.003$ , 95% CI: 0.20-0.36). The hazard ratio for treatment acceptance in the intervention group versus the control group was 1.58 (95% CI: 1.29-1.93).<sup>3</sup>

Furthermore, patients in the intervention group reported significantly lower levels of distress as measured by the Hospital Anxiety and Depression Scale (HADS) at the four-week follow-up (mean HADS score: 8.2 vs. 12.5,  $p<0.001$ ). Adherence to the first cycle of treatment was also higher in the intervention group (91% vs. 78%,  $P=0.008$ ). These results underscore the profound impact of targeted communication on both psychological well-being and practical treatment engagement. The mechanism of action appears to involve a reduction in cognitive dissonance and emotional barriers, allowing patients to process information more effectively and engage constructively with their treatment plan.<sup>3</sup>

## Limitations and Future Directions

While the findings are compelling, the study was limited by its observational nature and reliance on self-reported distress measures. The generalisability may also be constrained by the specific cultural contexts of the participating centres. For instance, cultural norms regarding illness and personal responsibility can vary significantly, potentially influencing the effectiveness of communication strategies. The relatively short follow-up period of four weeks also limits understanding of the sustained impact of these communication techniques on long-term adherence and patient outcomes. Future research should explore the long-term effects of such communication strategies on overall survival and quality of life, as well as investigate their applicability across diverse patient populations and cancer types. The development of standardised training modules for clinicians in this area could also facilitate broader implementation of these beneficial communication practices.<sup>4</sup>

### CLINICAL IMPLICATIONS

This ASCO presentation serves as a stark reminder that medicine extends beyond molecular pathways and surgical precision. The data, while from an observational study, provides a clear signal: ignoring the psychological undercurrents of a diagnosis, particularly patient self-blame, is a missed opportunity to improve outcomes. Clinicians, often pressed for time, might view addressing emotional states as secondary to delivering a diagnosis and treatment plan. However, the 28% increase in treatment acceptance demonstrates that a few minutes spent validating feelings and reframing culpability can have a more profound impact than any new drug. This isn't about being a therapist, it's about being an effective doctor.

For pharmaceutical companies and device manufacturers, this highlights an often-overlooked aspect of treatment efficacy. A drug, however innovative, cannot work if the patient does not take it. Investment in patient support programmes should extend beyond practical logistics to include resources for clinicians on empathetic communication. This could involve developing training modules or even integrating communication prompts into electronic health records. The industry's focus on adherence often centres on practical barriers, but psychological barriers are equally, if not more, potent.

Ultimately, this reinforces the foundational principle of patient-centred care. Guidelines from bodies like NICE or ESMO often touch upon holistic care, but the specific actionable steps for addressing self-blame are rarely detailed. This study provides a compelling case for integrating specific communication training into medical curricula and continuing professional development. It's not just about what we say, but how we say it, and the impact that has on a patient's willingness to fight for their own health. The evidence is now clear: a doctor's words are as much a part of the treatment as any prescription.

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