Welcome to the 2016 Summer edition of the BPOS Newsletter.

Thank you to Chris Hosker who has done a wonderful job of co-ordinating this newsletter over the past three years, I hope that I can continue to do the same!

This issue contains an overview of the recent BPOS conference, held in Cambridge, written by BPOS member Lydia Harkin. We also have a research overview written by the 2016 bursary winner, Sarah Allen, who writes about the influence of socioeconomic status on doctor-patient communication in head and neck cancer.

This issue also sees the continuation of a new regular feature: ‘PhD student spotlight’. In this issue’s spotlight, Jenny Harris from King’s College London tells us about her PhD research into Unmet needs: anxiety after treatment for breast cancer. Jenny is also one of two new BPOS Student Representatives, so if you are reading this newsletter as a PhD student or early-career researcher in Psycho-Oncology, then do feel free to get in touch with Jenny to share any ideas or thoughts that you have on how BPOS as a society could help to support you (jenny.harris@kcl.ac.uk).

In addition, we have a piece that contributes a clinical perspective to this newsletter. Helen Butlin has written about the role that hope can play in cancer treatment, and her experiences of working with hope and spiritual care as a psychotherapist.

If you would like to contribute an article to the newsletter, please do get in touch. Articles might be reports of studies in progress, reports of preliminary research findings, brief literature reviews, explorations of relevant methodological or ethical issues, conference reviews or book reviews. If you have something that you’d like to contribute, please contact me to discuss your ideas.

I hope you enjoy this issue.

Brooke Swash
Newsletter Editor
E: bes25@medschl.cam.ac.uk
Dear BPOS Members,

I’m delighted to be writing my first column as Chair of BPOS, following our 2016 annual conference in Cambridge in March. Having been a member of the BPOS executive committee for a number of years now, I am really looking forward to the challenge and privilege of leading and supporting the committee. I am very keen we continue to take forward our work supporting students and early career researchers in the field, and I am committed to building our membership and strengthening our links with IPOS and APOS so we contribute to advancing research and practice in psychosocial oncology at both a national and international level.

I know I am going to be supported by a very enthusiastic and hard-working executive committee! The recent AGM at the conference saw a number of changes to the committee: Laura Ashley completed her term as BPOS Chair, and I would like to say a big thank you to Laura for all the time, effort and enthusiasm she have given to the committee over the last few years. Chris Hosker also finished his term as BPOS Newsletter editor, and thanks also go to Chris for all his hard work. I am also really pleased to welcome some new members to the committee: Professor Claire Foster (University of Southampton) (Open position), Jenny Harris (Kings College, London) and William King (Chester University) who are going to share the Student Representative post, and Dr Sara Maclellan (University Aberdeen) (Co-opted member).

The 2016 annual conference was a really informative, inspiring and fun two days in a particularly lovely venue. We had over 70 delegates, a full conference programme and a great conference dinner – topped off with a quiz to challenge us all! There was a real buzz to the event, reflected in the very positive feedback from delegates. A big thank you to Annabel King, Brooke Swash and Stephanie Archer for organising the event. I’d also like to thank our keynote speakers, Elaine Chapman, Prof Sue Ziebland and Andrew Graystone, and all our presenters and delegates for their contribution to and support of the event. And congratulations again to our conference winners: Lydia Harkin (UCLAN) won the poster prize; Richard Kyle (Edinburgh Napier) won the Oral presenter (experienced); James McParland & Sara Portnoy (UCLH) won the Oral presenters (BPOS newcomers); The student bursary winner was Sarah Allen (University of Liverpool).

We hope many of you will consider submitting your work to our next annual conference on April 16 and 17th in Oxford. Details of the conference will be announced in the coming months on our BPOS website (www.bpos.org) and Twitter feed (@BPOSUK).

Again, I look forward to working with you all and representing BPOS over the next 2 years. We would really welcome feedback from members – so please do let us know about your research and practice, and your suggestions for how BPOS can best help and support you in your work.

Wishing you all a very productive and enjoyable Spring and Summer 2016.

Eila Watson
BPOS Chair
Email: ewatson@brookes.ac.uk
Anxiety affects around 35-55% of women with breast cancer at some point in the months after their first diagnosis (Carlson et al. 2004; Zabora et al. 2001; Goodwin et al. 2012) and whilst the intensity of anxiety often lessens with time, we know that for up to a quarter of breast cancer survivors symptoms of anxiety can persist for many months and even years after treatment (Burgess et al. 2005; Hopwood et al. 2010).

Many cancer survivors have unmet psychological supportive care needs that could be better identified and managed (Armes et al, 2009). In the UK, as with other chronic conditions, primary care services are playing an increasingly important role in monitoring and managing the care of people treated for cancer (Hutchings et al. 2013) delivering usual care without Prism. Practices will receive Prism and training randomly, and thereafter be able to use Prism with clinical and technical support. We will compare costs, processes of care, satisfaction and patient outcomes at baseline, 6 and 18 months, using routine data and postal questionnaires. We will assess technical performance by comparing predicted against actual emergency admissions. We will compare costs, processes of care, satisfaction and patient outcomes at baseline, 6 and 18 months, using routine data and postal questionnaires. We will assess technical performance by comparing predicted against actual emergency admissions.

Focus groups and interviews will be undertaken to understand how Prism is perceived and adopted by practitioners and policy makers. We will model data using generalised linear models and survival analysis techniques to determine whether any differences exist between intervention and control groups. We will take account of covariates and explanatory factors. In the economic evaluation we will carry out a cost-effectiveness analysis to examine incremental cost per emergency admission to hospital avoided and will examine costs versus changes in primary and secondary outcomes in a cost-consequence analysis. We will also examine changes in quality of life of patients across the risk spectrum. We will record and transcribe focus groups and interviews and analyse them thematically. We have received full ethical and R and D approvals for the study and Information Governance Review Panel (IGRP). Moreover, recent policy changes mean that breast cancer patients at a lower clinical risk of recurrence are being discharged by specialist cancer multidisciplinary teams to be followed up in the community by their GP (National Cancer Survivorship Initiative 2013), and so there is a trend towards less on-going monitoring from cancer services. In light of this, I think it is important to be able to identify those at greatest risk of on-going anxiety after primary adjuvant treatments by developing tools to help identify those who are likely to be more vulnerable to experiencing on-going symptoms of anxiety after discharged from specialist services.

Developing a predictive risk stratification model in psychosocial oncology

Whilst doing a MSc in Health Psychology, I worked for several years as a research assistant in...
My PhD seeks to develop and test a predictive risk stratification model (PRSM) for anxiety after treatment for non-metastatic breast cancer. Talking to my clinical colleagues it became clear that whilst there are established routes for psychological referrals and numerous supportive care interventions available (including individual, group and online), it was sometimes unclear to clinicians how best to identify those who might benefit long-term from supportive interventions. Against a backdrop of current inadequacies in meeting the psychological needs of patients, the possibility of developing a predictive risk stratification model to heighten clinical awareness and help identify those at greatest risk seemed like a potentially useful approach.

For the unfamiliar, predictive risk stratification models (PRSM) are designed to predict an individual's risk of having – or developing – a specific condition or outcome based on multiple variables (Moons et al. 2009; Hutchings et al. 2013) delivering usual care without Prism. Practices will receive Prism and training randomly, and thereafter be able to use Prism with clinical and technical support. We will compare costs, processes of care, satisfaction and patient outcomes at baseline, 6 and 18 months, using routine data and postal questionnaires. We will assess technical performance by comparing predicted against actual emergency admissions. Focus groups and interviews will be undertaken to understand how Prism is perceived and adopted by practitioners and policy makers. We will model data using generalised linear models and survival analysis techniques to determine whether any differences exist between intervention and control groups. We will take account of covariates and explanatory factors. In the economic evaluation we will carry out a cost-effectiveness analysis to examine incremental cost per emergency admission to hospital avoided and will examine costs versus changes in primary and secondary outcomes in a cost-consequence analysis. We will also examine changes in quality of life of patients across the risk spectrum. We will record and transcribe focus groups and interviews and analyse them thematically. We have received full ethical and R and D approvals for the study and Information Governance Review Panel (IGRP). Examples of some widely used PRSM are: the Nottingham Prognostic Index to estimate the long-term risk of cancer recurrence or death in breast cancer patients based on size of lesion, number of lymph nodes and grade of tumour (Galea et al, 1992); and the Manchester Triage System to assign priority based on clinical need among patients visiting accident and emergency departments (Mackway-Jones, 1997). Most research has focused on the development of PRSM related to primary disease outcomes such as death or the recurrence of a specific condition with only a few studies have considering outcomes relevant to on-going quality of life or adjustment (Moons et al. 2009).

Many possible individual, social and clinical factors have been associated with an increased risk of anxiety in people; however much previous research is cross-sectional, does not predict outcomes after adjuvant treatment, or is focused on determining how a particular prognostic factor influences risk after adjusting for other background variables.

We all know, from our own experience with the weather (e.g. the 1987 hurricane) and economics (e.g. the 2008 financial crisis) that, even when we have good quality prospective data, that predicting what will happen in the future is really, really difficult. Developing a PRSM for use in psycho-oncology won’t ever tell us what exactly will happen to a patients’ anxiety after treatment but it would hopefully be able to give us a useful estimate of individual risk which could be used to complement clinical judgement and patient-choice. I think that being able to risk stratify may have the potential to help primary care and cancer services more effectively and efficiently meeting the psychological needs of individual women and thereby improve the support they receive as well as their outcomes.

Addressing the research gap

My PhD aims to identify important predictors in women newly diagnosed with non-metastatic breast cancer of anxiety after active adjuvant treatment is complete (i.e. includes surgical, chemotherapy...
and radiological therapies, but not on-going hormone or biological therapies); develop a PRSM to determine the probability of anxiety in the presence of predictors in women with non-metastatic breast cancer and estimate the model’s predictive performance (Moons et al. 2009). My PhD complements my role in the eSMART study and involves a systematic literature review (with possible meta-analysis) to identify candidate person-related and clinically-related predictor variables from prospective data sources to inform development of the model. Important considerations will be the models’ discrimination (i.e. its ability to distinguish those with/without anxiety correctly) and calibration (i.e. that the predicted probability is in line with observed outcomes) and statistical validation.

**Wider implications**

I hope that this study will offer some preliminary evidence to inform the eventual development of a PRSM tool to inform clinical practice by helping healthcare professionals and patients make more appropriate, informed decisions and supplementing clinical information and quality of life. It may also have wider implications from a methodological perspective by exploring the utility of developing PRSM in psycho-oncology research.

The focus of the PhD is anxiety because this is the most prevalent of common mental disorders in women with breast cancer but in the future the lessons learnt from this could be adapted for other conditions.

Any questions, comments or if you are interested in potential collaboration and data sharing, please get in touch (jenny.harris@kcl.ac.uk).

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**References**


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**Keep in Touch**

**BPOS on Twitter**

BPOS now has a Twitter feed. If you or your organisation is also on twitter, you can follow us @BPOSUK. We are keen to use our twitter feed to inform people about general news, conferences, and funding information etc that is relevant to UK psychosocial oncology. If you have anything you’d like us to share with our members through twitter, please email Fiona Kennedy (f.kennedy@shu.ac.uk).

**BPOS e-Bulletin**

To ensure you receive our new quarterly e-Bulletin, please make sure that you let us have your up-to-date email address.

If there is something you would like us to include in the next e-Bulletin, please email Fiona Kennedy (f.kennedy@shu.ac.uk).

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Helen Butlin, Reg. Psychotherapist (CRPO), MDiv, PhD (Candidate), Spiritual Care Specialist (CASC) London Regional Cancer Program, London Health Sciences Centre, Ontario, Canada.

I often hear in my psychotherapy-spiritual care office themes captured by this statement by one individual, “It wasn’t the cancer killing me, it was the fear”. Together in sessions we sift the individual’s lived experiences, existential-spiritual struggles, hopes and strengths for ways to source a crucial ‘medicine’ that can be called ‘hope’.

Over 9 years of practice in oncology, I have come to hear first hand from those coming to our centre for treatment that how we source hope within oncology programs is a deeply embedded aspect of treatment. For many, along with the hope of treatments aiming to cure or stave off the tumour’s advances, hope-for-living-life, in the here and now for today, is almost invariably the next most crucial, existential and/or spiritual ingredient. For are told ‘cure’ is an option, hope becomes the singularly central question. “How do we do this?” was asked of me by one couple, beloved to each other when Rob was diagnosed with metastatic pancreatic cancer (Fazakerley, Butlin-Battler, & Bradish, 2012). That began a remarkable journey investigating, sifting their daily life and exploring many insights emerging through their process over the next 14 months profoundly meaningful, living answers to this question. Most movingly even in his dying process emerged new insights for them about meaning(s) of hope.

Oncology is as much about ‘treating hope’ as it is tumour cells. Every clinician is faced with individuals seeking in our faces, tone, and words for something that offers comfort and hope. Yet hope is highly individual and changes in its meaning daily and throughout the treatment trajectory. It can begin equated with cure but over time this equation can collapse and a person has to grapple with what hope truly means when cure is not an option. As one patient stated for a local newspaper article, “It wasn’t the cancer that was killing me, it was the fear.” Clinical practice wisdom knows that hope has some influence on outcomes and certainly on quality of life during and after treatment and as a result research has been expanding in this domain.

Discovering effective strategies for mobilizing this ‘strength of hope’ arising from the human psyche has been the focus of spiritual care services at the London Regional Cancer Program. Dr. Sugimoto, one of our surgical gynecological oncologists, stated in an interprofessional focus group on identifying spiritual distress, “Nothing extrinsic ever flags spiritual pain, you have to attune to the internal both in yourself and in the other.” It has taken the dedicated focus of many colleagues over the past six years to embed what is named as “Soul Medicine” through spiritual support to become an integrated part of patient care.

**Strengthening Spiritual-Existential Resilience**

Spiritual care is the art and practice of evoking, discerning and supporting personal resilience, trust, hope, faith and other aspects of spiritual strength within people in the midst of difficulties. Soul Medicine support groups and individual sessions through the spiritual care service at LRCP integrate wisdom and practices from different spiritual paths. Soul Medicine targets fear and despair seeking to strengthen a person’s capacity to meet the uncertainty of outcomes by sourcing deeply personal experiences of hope, meaning, connectedness and living for today.

In a focus group after running 10 groups I developed called “Soul-Medicine” (Butlin, 2015) that integrates Carl Jung’s insights about the inner compass of wisdom within the psyche we can all claim as our own that can sustain, guide and source strength, wisdom, hope, meaning...
in adversity we discussed how adding ‘soul-medicine’ into cancer care treatment had been experienced. One stated, “The spiritual support went deeper than empathy. It was the catalyst for the seed of hope inside me and kept it lit. I’m a different person now and fear is not part of my life as it was.” Narrative reports from Soul Medicine groups have included, “I focus on living each moment in a way I couldn’t before because I was afraid of dying,” “I feel more alive, even though I am dying.” “I notice the beauty all around me every day now.” For some, this has meant to face their premature dying with courage and determination in leaving a legacy not only of grief but also of great love, strength, and wisdom. For others it has meant a new life lived with newly claimed authenticity and courage to take greater risks for living more fully.

**Compassionate Presence as the Crucial Medicine**

Most importantly, the most critical medicine is one we all can offer and do every day. It is the medicine of ‘compassionate presence’. Often, this is the quality in our care that makes the most critical difference. Compassionate presence (Sinclair, McClement, et al., 2016; Sinclair, Norris, et al., 2016) can be a great catalyst for hope and inner strength. My oncology colleagues are deeply caring, dedicated human beings. We ‘treat hope’ in every encounter with compassionate presence being one of the most crucial ingredients and how we do that is the journey we walk together as staff and with our patients and we are all profoundly changed by it. We’ve glimpsed at LRCP that it is possible to integrate, for those patients who seek this, the spiritual and ‘soulful’ well-being into treatment pathways and this is a good news story for the future of an integrative paradigm for guiding cancer care.

**References**


Lydia Harkin, University of Central Lancashire

This year’s two day conference was held in the magnificent Madingley Hall in Cambridge, and offered an engaging programme with a diverse range of presentations and interactive workshops. The theme for this conference was a dual topic of integrated care and patient experiences.

On a bright spring morning on Thursday 3rd March, I joined 73 delegates in attending the 2016 BPOS annual conference. The setting was an inspiring historic former royal home. Our welcome was equally respectable as the day was warmly opened by Professor Eila Watson (from Oxford Brooks University), the new BPOS chair, who offered particular thanks to Dr Annabel Price (from the University of Cambridge) for organising the conference.

The first keynote speaker, Elaine Chapman, gave an impassioned presentation on the importance of integrating cancer care; co-ordinating health and social care services so they meet the needs of people living with cancer. Elaine provided us with insights from her extensive experience as a lead cancer nurse at Addenbrooks Hospital in Cambridge. She reminded us of the challenges facing the UK health service as cancer survivorship increases. It was clear that work which can promote efficient holistic care has growing relevance as we are expecting to care for 4 million cancer survivors by 2030.

Next was a series of oral presentations delivered to showcase new and ongoing cancer research in the UK. Jenny Young, from Edinburgh Napier University, described preliminary findings of the benefits of a holistic needs assessment for cancer patients. Dr Brooke Swash, from University of Cambridge, presented qualitative experiential evidence of end of life care, and highlighted challenges for both carers and healthcare professionals. Dr Lauren Matheson, from Oxford Brookes University, presented the findings of a meta-synthesis of younger, gay, and unpartnered men’s’ unique experiences of prostate cancer. Abigail Clifton, from King’s College London, presented the findings of a qualitative study of cancer screening in mental health services. Finally, James Millman, from Queen’s University Belfast, presented preliminary qualitative findings of knowledge shared between cancer and mental health clinicians. These presentations threw light on how integrated care might be implemented more efficiently for people with unique and varying psychosocial needs after cancer.

A delicious hot buffet and an irresistible selection of cakes were available for lunch. After this, delegates were offered the opportunity to attend a choice of two interactive workshops; ‘patient and public involvement: what it is and how to do it’ or ‘setting up a psycho-oncology service: snakes and ladders’. I attended the former workshop, facilitated by Dr Sue Williamson (University of Central Lancashire), Dr Jo Brett (Oxford Brookes University) and Dr Helen Bulbeck (Director of services at the Brainstrust). This session invited input from all members of the room and I was delighted to find that this discussion was often led by cancer service users. Thus, a practical and enlightening conversation ensued concerning how to increase patient involvement during different stages of research development and dissemination.

Andrew Graystone kicked off the second keynote speech with a humorous, moving, and thought-provoking discussion of his personal cancer experience. He questioned how the public, healthcare professionals, and charitable organisations communicate about cancer, particularly illuminating the way battle metaphors can negatively impact the experience of living with the disease. Andrew’s engaging talk epitomised the purpose of the conference, highlighting the prominent role that patient experiences should play in future education and research in cancer.

The final presentations of day one came in the form of a networking session and invitation to view the exceptional 37 posters that were present at the conference. There
were a diverse range of studies presented, including a good mix of quantitative and qualitative research into cancer care. I found this an inspiring snapshot of the work being done in the UK to improve the lives of people living with cancer.

Thursday ended with a superb three course meal, followed by the opportunity to exercise our competitive energy and common knowledge in a quiz. Admittedly, in spite of being part of a team which could boast several PhD’s and postgraduate qualifications, my team ranked poorly in the overall scores. However, that didn't spoil the evening, as the quiz master was brilliant, and the atmosphere was friendly and light-hearted.

The second day of the BPOS conference was opened by the third and final keynote speaker, Professor Sue Zeibland from the University of Oxford. Sue presented us with timely evidence of the importance of experience-based health research. Sue offered insight from her work with the charity DIPEX and the award winning patient experience website Healthtalks.org. This talk provided an excellent example of how cancer care and research can adapt to the growing cancer survivor population by utilising digital and technological advancements.

The following session, a series of five oral presentations, discussed research taking place to improve women’s cancer experiences and outcomes. This began with Professor Kinta Beaver, from the University of Central Lancashire, presenting her work into the effectiveness of telephone follow-up care for women with endometrial cancer. Dr Elaine Wilson, from University College Dublin, presented a thematic discussion of the challenges experienced by young women with early stage breast cancer. Karen Scanlon, from Breast Cancer Care, provided an insightful view into what patients perceive as gaps in service provision. Dr Jo Brett, from Oxford Brookes University, talked through women’s non-adherence for adjuvant endocrine therapy following breast cancer treatment, with evidence from a qualitative research project. Finally Dr Richard Kyle, from Edinburg Napier University, presented an evaluation of a walking-led intervention for women living with breast cancer. These oral presentations highlighted the complex needs of women living with cancer, whilst offering cost effective, evidenced based solutions to improving the psychosocial care of patients.

Prior to lunch I was invited to connect and network with fellow PhD research students and early career researchers. This was an exciting opportunity; this was my second BPOS conference, and as an early career researcher it was incredibly reassuring and motivating to see the progression of fellow early career cancer researchers.

The third and final session of oral presentations took place on Friday afternoon. This session reminded us of the varying patient and family experiences of cancer. Firstly, Joanne Haviland, from the Macmillan Cancer Survivorship Research group, presented the findings of two longitudinal studies of patient wellbeing after colorectal cancer. This detailed colorectal patient’s pathways of cancer recovery, and highlighted patients’ most problematic experiences when undergoing treatment. Emily Moffat, from Queen’s University Belfast, presented a systematic review of families’ support needs after a cancer diagnosis. Dr James McParland and Sarah Portnay, from the University College London Hospital, presented a novel and creative approach which enabled teenagers and young adults to express their feelings about the impact of their cancer diagnosis. They were joined by three young adults who shared their experiences with the approach. This service user testimonial was an excellent way to demonstrate the need for creativity in young adults’ cancer care. Following this, Sam Cockle, from the University of Surrey, offered insight into the experiences of families who have travelled to have their children’s brain tumours treated with proton beam therapy. Collectively, these presentations demonstrated that patient experiences could and should be the inspiration for developing new, patient-centred psychosocial care.

The conference concluded with announcements that three delegates had won awards for their presentations. The best newcomer was awarded to Dr Richard Kyle, whilst Dr James McParland and Sarah Portnay were awarded the prize of best oral presentation. I was also delighted to be awarded the best poster presentation of the conference, for a poster presentation of my PhD findings into online cancer communication and social networks.

In all, I thoroughly enjoyed the 2016 BPOS conference. The presentations were consistently high quality in evidence and expertise. Moreover, as an early career researcher, it can sometimes be daunting attending national conferences, but I found that BPOS facilitated a superb atmosphere which was both encouraging and inspiring. This conference has really enriched
my knowledge of psychosocial oncology research taking place in the UK, and proved a fantastic opportunity for me to network with fellow early career researchers, patient representatives, patient support organisations, and respected and established names in psychosocial oncology. I have saved the dates for next year’s conference, and strongly recommend that anyone with an interest in psychosocial oncology does so too; 16th and 17th March, 2017 in Oxford.

Lydia has recently been awarded a PhD from the University of Central Lancashire, and is currently assisting on a research project at Nottingham Trent University. She can be found on Twitter @ljharkin

Free Online Training for Oncology Professionals: Supporting Patients with an Intellectual Disability

You are invited to take part in online training which focuses on communicating with people with an intellectual disability. These skills may also be transferrable to your everyday practice. This training is certificated.

We are also evaluating the training – and have three short questionnaires to be completed before and after the training, and another six weeks later. We expect that, including all questionnaires and the training, the package will take you no longer than 3 hours. Participation is voluntary, and all data will be secure and confidential. If you want to find out more about this exciting project, please follow the link below:

https://chester.onlinesurveys.ac.uk/cpid1

Many thanks,
Samantha Flynn
Email: samantha.flynn@chester.ac.uk

Chester Research Unit for the Psychology of Health, University of Chester

Please note: The training site is best viewed in Internet Explorer. It also works well in Firefox and Chrome. The site is known not to work particularly well with Safari.
Sarah Allen, University of Liverpool

While attending the BPOS conference in March I presented a poster entitled 'Is social inequality related to different patient concerns in routine oral cancer follow-up clinics?'. This study explored the socioeconomic differences in patient-reported quality of life and Patient Concerns Inventory—Head and Neck (PCI-HN) scores of oral cancer patients post-treatment.

The PCI-HN is a 56-item question prompt list which patients complete before a follow-up appointment. It has been tailored specifically to head and neck cancer patients, and allows the patient to indicate any concerns which they wish to discuss in their appointment. These range from physical, treatment-related, social care and psychological concerns. Once completed, the PCI-HN results are given to the consultant to facilitate discussion with the patient and help the patient to bring up any concerns important to them, which they may have otherwise found difficult.

The study found that PCI-HN scores did not significantly differ by socioeconomic status (SES), however quality of life did differ, with patients at the lower end of the socioeconomic gradient reporting significant problems with mood and recreation. This suggests that low SES patients are experiencing worse quality of life, yet are not reporting these issues to a healthcare professional.

Previous studies have found that low SES patients tend to participate less actively in their consultations than high SES patients, as they ask fewer questions, are less likely to volunteer information unasked or express their opinion, and show a lower preference for shared decision-making. Furthermore healthcare professionals tend to approach low SES patients in a more directive manner by giving them less information, and spending less time building rapport, explaining or giving advice to these patients. This has been found with a number of different patient groups, however head and neck cancer patients have been neglected in this field of study. In addition there seems to be a lack of studies exploring the patient-reported beliefs, narratives and experiences which may underlie these SES differences.

My PhD project aims to explore whether and why SES affects doctor-patient communication with head and neck cancer patients, through the use of quantitative and qualitative analyses. The first phase will involve the quantitative coding of audiotaped head and neck oncology review appointments using Verona Coding Definitions of Emotional Sequences (VRCoDES— a method of coding doctor-patient communication and emotional expression during medical appointments), the results of which will be compared by patient SES. The second phase will consist of observation and audiotaping of head and neck oncology review appointments, in addition to patient interviews. These results will also be compared by SES. My project will also explore whether the PCI-HN influences doctor-patient communication through the use of VRCoDES to analyse head and neck appointments during a Randomised Controlled Trial of the PCI-HN. I will also explore the impact this has on different socioeconomic groups.

The results of this project will contribute to our understanding of SES differences in doctor-patient communication with head and neck cancer patients, and why these differences might exist, as perceived by the patients. This will impact whether the PCI-HN is used on a wider scale, and the development of any other interventions to reduce socioeconomic differences in doctor-patient communication.
will commence in May, with recruitment for the second phase starting around July. My PhD is funded by The National Institute of Health Research Collaboration for Leadership in Applied Health Research and Care North West Coast (NIHR CLAHRC NWC).