imaging comparable to external beam using dedicated set-ups with an afterloader inside the MRI room. On the other side it seems very promising to invest into in-vivo dosimetry methods. Other forms of volumetric imaging in the treatment room may be another alternative. As the MR image series for treatment planning already contains already the delivery device and the anatomy, the situation during dose delivery can be verified with different methods with co-registration and may reach then almost the same accuracy as if performed simultaneously together.

Real in-room US imaging has been performed since long with prostate brachytherapy for direct guidance of needle insertion, target definition and on-line dose planning. Especially HDR techniques applying ultrasound for treatment planning before and during needle insertion, again for verification just before dose delivery, leaving the ultrasound probe in place and finally performing an ultrasound image directly after dose delivery have probably the highest accuracy possible. Combining such methods with MRI may lead to the ultimate accuracy in terms of target definition, OAR localization, treatment planning and dose delivery verification.

Combinations of different imaging techniques with the applicator in place, even generated in different rooms, seem to be the future in brachytherapy. Already by now brachytherapy planning was performed as adaptive procedure, taking into account pre-treatment imaging information and dose optimization based on the situation directly before dose delivery. The adaptive process includes image guided applicator placement. The term “in-room adaptive imaging” in brachytherapy can be extended to an overall definition of a “room” inside the patient visualized via adaptive imaging containing target, OARs and the delivery device in one image.

Symposium: Communication with patients

SP-0487
Patient’s Perspective
E. Haenssens1
1Trinity College Dublin, Dublin, Ireland Republic of

Good communications are primarily thought to involve skills of articulation. However, this presentations makes the case for listening as the recurrent starting point in patient interactions. Listening is deceptive. Generally viewed as a “soft skill” the challenges of listening are easily overlooked. Engaging requires gating (active listening, observing, clarifying, and feeding back). Drawing upon his experience as an oncology patient and his academic background and training in communications and social science, Eddie explains why we are prone to assume we are good listeners despite evidence to the contrary. Demonstrating a number of relevant biases and fallacies, he explains why there is no necessary link between assumption of competence and actual competence. He presents concrete examples from the patient perspective of excellent and poor communications and their positive and negative outcomes. The presentation concludes with an overview of useful ways to reflect upon the issues, improve communications, and enhance overall outcomes.

SP-0488
Healthcare professional’s perspective
G. Sancho Pardo2
2Hospital de la Santa Creu i Sant Pau, Barcelona, Spain

Training in communication and interpersonal skills was not considered a relevant part of the training at medical school and during the specialty residency programmes. Medical doctors therefore learned by observation of how their seniors performed. After some time one realizes that effective communication with patients involve both content and style and that being caring, nice and logical is not enough. Based on the available literature, this presentation will look into the factors influencing the patient-healthcare professional communication. I will focus on how healthcare professionals are involved in the process of communication and how they can improve it.

When we are visiting a patient we have to ensure that several aspects are well covered. First we need to identify the patient’s problems and concerns and their impact on their family and daily life. Second, we should give clear information and advice about their disease, their treatment and their prognostic. Giving patients tailored information of what and how you think they want to know might be not enough. In many occasions breaking bad news is unavoidable, and patients may express some strong emotional reactions that you should be able to understand and cope with. One has also to be aware that some patients do not want to know the diagnostic and noticing related to the disease and few patients will move into denial. Third, we should ensure that patients are aware of the situation, that they have not misunderstood the information we have given them and that they trust us. It is of paramount importance to empathise with the patient. Remember that verbal information goes together with visual messages and physical contact. Patient depending factors like race, sex, age, language, culture, socioeconomic status, disability or communication barriers could condition the process of communication. Healthcare professional’s factors such as time, job strain, working conditions, work engagement and personal life may spoil communication with patients.

Doctors have to be aware that patients today have access to information about their disease from their relatives, friends, books, media and the Internet that clearly impacts on the relation with patients and on the communication process. An issue that deserves special attention is the recruitment of patients for clinical trials. Patient recruitment partially depends on a relation of trust with the patient and in the doctor’s ability to communicate the importance of joining a trial. It has been shown that training in communication about trials may influence in the recruitment. However, trial design, especially when one arm offers placebo or less treatment, highly contributes to patients’ decline. It has been suggested that involving patients and patients’ organisations in the design and development of clinical trials could accelerate research and make it more effective.

There is a need for training in communication skills in medical education. Training healthcare professionals how to be more effective in communication with patients will provide a benefit for them as well as for the patients.

SP-0489
RTT/Nurse’s perspective: patient is the key element of communication
L. Koevoets2
2Dr. Bernard Verbeeten Instituut, Radiotherapy Breda, Tilburg, The Netherlands

Patient is the key element of communication. Where do we stand regarding communication with our patients? Our mission statement: we want to give our patients the best possible experience. We really want to connect. How do we try to achieve this? Personal contact and support as much as possible “Do what you say and say what you do”. Honest and clear information. Information in common words, but also use of visual aids. This is rooted into our Institute by use of a timeline: who explains what at which particular stage in the treatment and what tools can be used? Example: we inform all our patients in a private briefing before their treatment starts. The role of the RTT in communication with the patient. Explanation of the treatment. Connecting with other disciplines to support the patient. A person who a patient can approach. Provision of personal coaching programme to help patients to quit smoking. We check the satisfaction of our patients on a regular basis. How do some do that? We try to stay in dialogue with our patients. All staff are trained for giving and receiving feedback.

What do we try to attempt with our information conversation? The information given before treatment is
aimed at providing patients with more knowledge. Armed with insight, personal behaviour patterns which influence treatment outcomes can be challenged. Our belief is that a well informed patient will be less anxious and insecure. The information that we give is to repress misconception, reduce unrealistic fears and provide predictive information. The latter is to let the patient know what we do during the radiation and why, further to inform the patient what side effects the patient can develop after an period of time. We try to support the patient in different areas. We try to meet within the needs in the pyramid of Maslow. It states that a human being among other things is in need of safety and security, need for social contact and is in need of appreciation and recognition. In the conversation we try to acknowledge their fears and and recognize that these may exist and by giving information we try to repress those fears. We try as much as possible to be really in contact with the patient and to connect with the experiences of the patient. To reassure them and to let them know what we do and why, we try to let them feel safer and more certain about the process they will be going through. To give the patient also some sense of control over the radiation we hope to achieve that the patient feels he/she also affects the process and thus have the situation more under control. The information is given with use of an PowerPoint presentation with supports the story the radiation technician is giving. In this presentation he shows pictures that support the story. The radiation technician uses the knowledge that a person remembers 20% of what they read, 35% of what they see and 55% when you combine these two.

**SP-0490**

**Interaction between patients and professionals: a psycho-oncologist’s view**

_E. Van Hoof_

_Vrije Universiteit Brussel, Department of Psychology, Brussels, Belgium_

**Purpose or Objective:** Stress influences our communication: the way how we interpret the world, our communications style we use to interact with our environment and our internal communication. During the presentation, neuropsychological insights into communication will be presented. These insights will be used to introduce some pragmatic intervention to monitor and control communication.

**Materials and Methods:** a literature review of the impact of stress on our information processing system and hence, our communication and of possible intervention that can positively influence our information processing

**Results:** Several brain mechanisms can negatively influence our communication. Our knowledge of these mechanisms is key in understanding and identifying possible communication styles. In cancer, we see many patients and their relatives struggling with the information-processing. Coping strategies like avoiding and neglect, for instance, are effective in the short-term but in the long run, flexibility in coping is required to ensure shared decision making in cancer care. Indeed, shared decision making is the priority in cancer care. Caregivers, specialists and the patients collaborate ensure the best possible cancer care. Shared decision making requires an efficient information processing. However, stress has a strong impact on this shared decision making process. Results from cognitive behavioral interventions and intervention based on positive psychology positively influence information processing and stress-levels. Including these strategies can facilitate emotion regulation and hence, shared decision making in cancer care.

**Conclusion:** Stress negatively impact our information processing and hence, our communication. On the other hand, communication is the central factor in shared decision making. Caregivers, specialists and patients should always be aware of these possible disruptive factor in order to ensure shared decision making in cancer care.