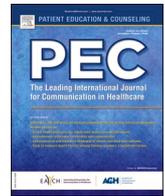


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# Patient Education and Counseling

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## Breast cancer patient experiences with and preferences for time alone with their cancer care team

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### ARTICLE INFO

#### Keywords:

Patient-provider communication  
Time alone  
Breast cancer  
Support person  
Companion

### ABSTRACT

**Objective:** Clinicians often suggest that breast cancer patients bring a companion with them to cancer-related appointments. However, a companion's presence shifts the interaction at a minimum from dyadic to triadic, with potential consequences for effective communication. It is not well documented how often breast cancer patients have time alone with their cancer team, how long any time alone lasts, and if patients are satisfied with the amount of time alone.

**Methods:** Current (undergoing treatment;  $n = 150$ ) and former patients (treatment completed;  $n = 202$ ) breast cancer patients who regularly bring a companion with them to their cancer care visits completed an online questionnaire about the time they spend alone with their oncology team.

**Results:** Current patients reported fewer instances of time alone with their care team than former patients. Overall, most patients reported that the frequency of time alone was about right and that they rarely brought up questions or topics that they would not want to raise with their companion present. Of the patients who reported having no time alone ( $n = 38$ ), the primary reported reason was that they did not want time alone with their cancer care team.

**Conclusions:** Approximately 1 in 3-4 patients reported that there were questions or topics that they feel more comfortable raising when they have time alone with their healthcare team, representing an important need for these patients. Most patients reported wanting time alone with their cancer care team and reported being satisfied with the amount they do have.

**Practice implications:** Results are a positive reflection on the amount and frequency of time alone that breast cancer patients desire throughout the cancer care trajectory. To support patient communication needs, clinicians should provide at least some time alone with their patients, particularly when the patient regularly attends visits with a companion and may otherwise not have the opportunity to be alone with their cancer care team.

## 1. Introduction

Breast cancer patients often turn to their social support network (e. g., spouses, family members, and close friends) to help manage their diagnosis, treatment, and related symptoms [1,2]. Clinicians and patient advocacy groups suggest that patients regularly bring a companion with them to cancer-related appointments as support [3], and patients often report their involvement as helpful [2]. For example, patients report wanting their companion to assist with decision-making and find their presence in these conversations helpful [2,4]. However, there are times

when cancer patient and companion goals within appointments diverge [5], creating barriers to effective communication with the oncology care team. Further, cancer clinicians report concerns that companion presence during appointments may limit the openness of patient communication [6], potentially hindering clinicians' assessment of the patient's symptoms and treatment plan. It is important to understand the positive aspects of companion presence while acknowledging the potential communication challenges that arise from their involvement.

One way that potential misalignment of communication can be addressed is by providing patients time alone with their cancer care

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<https://doi.org/10.1016/j.pec.2025.109178>

Received 29 January 2025; Received in revised form 9 May 2025; Accepted 10 May 2025

Available online 17 May 2025

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team, without their companion present. Although research on such triadic communication has advocated for offering time alone to cancer patients [6], breast cancer patient experiences of time alone with the cancer care team have not been systematically documented. This paper will describe (a) how often breast cancer patients have time alone with their cancer team, (b) the length of this time alone, and (c) whether patients are satisfied with the amount of time alone they have. Additionally, to address the potential differences in care needs across the cancer illness trajectory [7], this study investigates whether patients currently undergoing treatment report different experiences with time alone than those who have completed treatment.

## 2. Methods

### 2.1. Participants and procedure

Current breast cancer patients (in active treatment) and former patients (treatment completed) who regularly bring a companion with them to their cancer care visits were recruited through the Love Research Army® research registry hosted by the Dr. Susan Love Foundation for Breast Cancer Research. To detect a small to medium effect size (Cohen’s  $d = 0.35$ ) between current and former patients with 80% power at an alpha level of 0.05 (critical  $t = 1.97$ ), we aimed to recruit at least 140 participants per group. Participants completed an online questionnaire about their time alone with their oncology team as part of a broader study of patient-provider communication in breast cancer appointments. Data was collected starting June 2020 and closed December 2023. Eligible patients were 18 years or older, US-based, able to complete the survey online in English, able to provide informed consent, and sometimes or regularly attended oncology visits with a companion. Participants had the opportunity to enter a drawing for one of three \$50 gift cards. This study was approved by the Rutgers University Institutional Review Board (IRB #E17-664).

### 2.2. Measures

Demographic information was asked for each participant. Participants completed questions about the time they spend alone with their cancer team (without their companion present). Participants were first asked about whether they had time alone. If time alone was indicated, participants were then asked about the length of the time alone, the frequency of the time alone, and changes in their communication patterns and sharing when they are alone with their care team. If participants indicated they had no time alone, they were asked a different set of questions related to their preferences for time alone and whether that was concordant with their experiences. Specific items are provided in Table 2.

### 2.3. Analyses

Means and standard deviations were assessed for each item. Differences in responses across current and former patient groups were assessed using chi-squared tests. Post-hoc power analysis revealed actual power to detect a small effect size was 0.88 at an alpha level of 0.05 (critical  $t = 1.97$ ). Analyses were completed using StataMP version 18.5.

## 3. Results

### 3.1. Participants and demographics

In total, 175 current and 237 former patients completed the survey. Participants were not included in subsequent analyses if they completed < 80 % of the survey ( $n = 40$ ), reported having a non-breast cancer diagnosis ( $n = 17$ ), or reported having male breast cancer ( $n = 3$ ). This resulted in 150 current and 202 former patient responses retained for analysis. Patients reported an average age of 57 ( $M_{current} = 57.6$ ,  $M_{former}$

$= 57.2$ ; range 29–83). Most respondents were non-Hispanic white, were married/living as married, and obtained a bachelor’s degree or additional education. The two patient groups had no significant differences across the demographic variables (see Table 1).

### 3.2. Descriptive statistics and comparison across patient groups

Current and former breast cancer patients reported having time alone with their cancer team (without their companion present) during some to most of their visits. Frequencies of response options are listed in Table 2. Current patients reported having fewer instances of time alone with their care team than former patients ( $p = 0.01$ ). However, when patients had time alone with their care team, current and former patients both reported about 10–15 min alone ( $p = 0.83$ ). Overall, current and former patients felt that the frequency of time alone with their cancer care team was about right ( $p = 0.49$ ). During the time alone with

**Table 1**  
Demographic information and descriptive statistics comparing current and former breast cancer patients.

	Total ( $n = 352$ )	Current patients ( $n = 150$ )	Former patients ( $n = 202$ )	<i>p</i> - value
Age – mean (SD)	57.36 (11.99)	57.64 (12.35)	57.15 (11.74)	0.71 NS <sup>†</sup>
Years since diagnosis – mean (SD)	2.54 (2.20)	1.26 (2.29)	3.48 (1.57)	< 0.01 <sup>†</sup>
Census location – frequency (%)				0.41 NS <sup>†</sup>
Northeast	58 (16.71)	25 (17.12)	33 (16.42)	
Midwest	70 (20.17)	30 (30.55)	40 (19.90)	
South	114 (32.85)	41 (28.08)	73 (36.32)	
West	105 (30.26)	50 (34.25)	55 (27.36)	
Education – frequency (%)				0.56 NS <sup>†</sup>
High school graduate	3 (0.86)	2 (1.37)	1 (0.50)	
Vocational, technical, business, or trade school certificate or diploma	20 (5.76)	8 (5.48)	12 (5.97)	
Some college	51 (14.70)	25 (17.12)	26 (12.94)	
Bachelor’s degree	118 (34.01)	52 (35.62)	66 (32.84)	
Master’s, professional, or doctoral degree	155 (44.67)	59 (40.41)	96 (47.76)	
Race – frequency (%)				0.15 NS <sup>†</sup>
White/Caucasian	320 (91.69)	141 (95.27)	179 (89.05)	
Black/African American	16 (4.58)	4 (2.70)	12 (5.97)	
American Indian/ Alaska Native	2 (0.57)	0	2 (1.00)	
Asian/Asian American	4 (1.15)	0	4 (1.99)	
Multiracial	7 (2.01)	3 (2.03)	4 (1.99)	
Ethnicity – frequency (%)				0.62 NS <sup>†</sup>
Hispanic/Latino	39 (11.11)	18 (12.08)	21 (10.40)	
Marital status – frequency (%)				0.64 NS <sup>†</sup>
Single	24 (6.82)	12 (8.00)	12 (5.94)	
Married/living as	281 (79.83)	123 (82.00)	158 (78.22)	
Divorced	23 (6.53)	8 (5.33)	15 (7.43)	
Widowed	12 (3.41)	3 (2.00)	9 (4.46)	
Separated	5 (1.42)	2 (1.33)	3 (1.49)	
Dating	7 (1.99)	2 (1.33)	5 (2.48)	

Note. <sup>†</sup> Two-tailed  $t$ -test. <sup>‡</sup>  $\chi^2$  test. US Census Division: Northeast (CT, ME, MA, NH, NJ, NY, PA, RI, VT); Midwest (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI); South: (AL, AK, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV); West: (AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY).

**Table 2**  
Item wording and descriptive statistics.

Item	Response options	Current (n = 150)	Former (n = 202)	$\chi^2$ p-value
1. Is there time alone (without your companion) to talk with your medical team during the oncology visit?	None of the visits (0)	26	15	0.01
	Few of the visits (1)	19	18	
	Some of the visits (2)	44	46	
	Most visits (3)	28	60	
	Every visit (4)	36	61	
2. When you have time alone with the healthcare team without {your companion}, how long is it on average?	About 5 min (1)	11	17	0.84
	Less than 10 min (2)	21	33	
	About 15 min (3)	37	53	
	About 20 min (4)	21	30	
	About 30 min (5)	18	28	
	Around an hour (6)	5	6	
3. Do you think the frequency of the time alone with the healthcare team is:	Far too little (1)	0	3	0.49
	Too little (2)	9	13	
	About right (3)	113	167	
	Too much (4)	1	3	
	Far too much (5)	0	0	
4. When you are alone without {your companion} with the healthcare team, would you say:	I share a lot more (1)	5	10	0.57
	I share a little more (2)	20	40	
	I share about the same (3)	93	127	
	I share a little less (4)	7	6	
	I share a lot less (5)	1	1	
5. When you are alone with the healthcare team without {your companion}, how often do you ask questions or raise topics that you do not want to ask or raise when {your companion} is present?	Never (0)	53	73	0.83
	Rarely (1)	34	46	
	Sometimes (2)	24	44	
	Often (3)	7	12	
6. Which of the following best describes your view of time alone with the medical team (without your companion)?	Always (4)	6	10	
	I really do not want time alone with the medical team during the visit (1)	11	11	
	I do not want time alone with the medical team during the visit (2)	7	4	
	I want time alone with the medical team during the visit (3)	3	0	
	I really want time alone with the medical team	2	0	

**Table 2 (continued)**

Item	Response options	Current (n = 23)	Former (n = 15)	$\chi^2$ p-value
7. Which of the following best describes your view of the frequency of time alone with the medical team (without your companion)?	during the visit (4)			0.12
	I never want time alone with the medical team during the visit (1)	10	12	
	I rarely want time alone with the medical team during the visit (2)	9	3	
	I sometimes want time alone with the medical team during the visit (3)	1	0	
	I often want time alone with the medical team during the visit (4)	3	0	

*Note.* {Your companion} represent a piping of participant responses to a question that asked for their companion’s initials, name, or nickname.

the care team, both current and former patients reported only rarely or sometimes bringing up questions or topics that they would not want to ask or raise with their companion present ( $p = 0.83$ ). About 1 in 4 current (24.7 %) and 1 in 3 former (32.7 %) patients did report asking different questions or raising topics they did not want to discuss with their companion present. Few patients reported having no time alone ( $n = 38$ ). Of the current and former patients who reported having no time alone ( $n = 23$  and  $15$ , respectively), the primary reason reported for why they had no time alone was because they did not want time alone with their cancer care team ( $p = 0.23$ ). Although this difference was not statistically significant, among former patients who had no time alone ( $n = 15$ ), none endorsed wanting time alone. By contrast, at least some current patients ( $n = 5$ ) who had no time alone indicated they wanted time alone.

#### 4. Discussion and conclusion

##### 4.1. Discussion

Overall, breast cancer patients in our study generally report some time alone with their cancer care team without their companion present. This experience was reported for patients seeing their care team both during and after treatment. When patients in our study had time alone without their companion, it was typically 10–15 min, and participants felt that was about the right amount of time. Surprisingly, patients did not report sharing much more with their healthcare team when they were alone but ~1 in 3 (former) or 4 (current) patients reported that there were topics they felt more comfortable sharing when they had time alone. Although a smaller proportion of the patients in our study, this difference in sharing aligns with previous research indicating that there are topics (such as body image and fear of death) that cancer patients do not feel comfortable discussing in the presence of their companion [8–10]. To note, patients did not report *never* sharing more with their care team while alone without their companion, pointing to at least some need for this opportunity. Patients reported being satisfied with 10–15 min of time to communicate with their clinician alone, without their companion.

Patient-centered care tasks clinicians with creating treatment plans aligned with patients’ beliefs and creating shared power within clinical interactions [11,12]. Our results suggest that providing 10–15 min of

time alone for breast cancer patients without their companion aligns with patient-centered care. Although patients in our study reported not having much that they would rather share privately with their care team, by providing that time alone, clinicians open space for creating alignment with patients' beliefs apart from their companion. Companions play an important role in supporting breast cancer patients, however, patients in this study still preferred to have time alone with their cancer team. Further, in providing time alone, clinicians can facilitate shared power by recognizing patients' autonomy. Even if patients do not utilize time alone to share issues or topics they previously held back, providing at least some time alone regularly may facilitate comfort if issues or topics arise.

A limitation of the current study is that the demographics of the participants were relatively homogenous and thus do not reflect the demographics of breast cancer patients in the United States. Given the documented effects of sociodemographic concordance between patients and providers [13], it is possible that our patient population were more comfortable with clinicians overall than other populations of breast cancer patients. The Love Research Army® research registry (and thus this sample) reflects a highly educated population of cancer patients who may be especially involved and motivated. Thus, this sample may have differences in how comfortable patients felt in clinical interactions overall compared to the general population [14]. Additionally, results reflect a cross-sectional survey response from patients. Thus, patients' retrospective reports of their cancer care experiences may reflect the time alone they had in their most recent encounters, which may or may not be representative of their overall experiences.

#### 4.2. Conclusion

Approximately 1 in 3 or 4 patients did report that there were questions or topics that they feel more comfortable raising when they have time alone with their healthcare team, representing an important need for these patients. Most patients reported wanting time alone with their cancer care team and reported being satisfied with the amount they do have. Results of this study are a positive reflection on the amount and frequency of time alone that breast cancer patients prefer to have throughout the cancer care trajectory.

#### 4.3. Practice implications

We recognize that 10–15 min of time alone during each appointment may not be feasible. However, results demonstrate a desire from patients for some time alone. To support patient communication needs, clinicians should strive to provide at least some time alone with their patients, particularly when the patient regularly attends visits with a companion and may otherwise not have the opportunity to be alone with their cancer care team. The results of this study are a positive reflection on the amount and frequency of time alone that breast cancer patients prefer to have throughout the cancer care trajectory such that needs are being met for most patients by current practices.

#### Funding

This study was supported, in part, by Rutgers School of Communication and Information's Small Grants for Individual Faculty Research (GIFR). The first author is supported by the National Cancer Institute of the National Institutes of Health under award number: 1F99CA294165-01. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

#### Ethics

This study was approved by the Rutgers University Institutional Review Board (protocol and approval #E17-664).

#### CRedit authorship contribution statement

**Katie A. Devine:** Writing – review & editing, Methodology, Investigation, Conceptualization. **Maria K. Venetis:** Writing – review & editing, Methodology, Investigation, Conceptualization. **Elizabeth Broadbridge:** Writing – original draft, Visualization, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Lauren E. Lee:** Methodology, Investigation, Conceptualization. **Kathryn Greene:** Writing – review & editing, Supervision, Methodology, Investigation, Funding acquisition, Conceptualization.

#### Declaration of Competing Interest

None.

#### Acknowledgements

The authors would like to thank the participants who spent their time and energy to provide these data.

#### Data availability statement

The deidentified data that support the findings of this study are available by request from the corresponding author.

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