

LETTER TO THE EDITOR

Repeating what is already known without increasing understanding is a waste of resources

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Dear Editor,

Recently, *Palliative & Supportive Care* published a study by Meggiolaro et al. (2015) that had the dual purpose of examining the rate of and difference between “emotional distress” (measured by the Distress Thermometer) and “maladaptive coping” (gauged with the Mini-MAC) and examining the association between those variables and cancer patients’ subjective perceptions of their interactions with their doctors (using The Physician Patient Satisfaction with Doctors Questionnaire). In the introduction to that paper, the authors made it clear that these topics certainly have been elaborated on in many previous studies, but they differentiated their work by including patients from three different countries in order to “extend our understanding.”

Reading this study, however, a significant question presents itself: How can a repetition of correlations between these variables, even if conducted in different countries, “extend our understanding”?

After ambitious statistical elaborations, Meggiolaro and colleagues (2015) provide us with many exact percentages, correlational coefficients, and *p* values. They then in the discussion summarize as follows:

- Many patients are distressed, and these results are “in line with other studies.” “Constantly monitoring” is recommended.
- Many patients make use of “maladaptive coping,” and this is “confirming what [is] already shown.” The “psychosocial domain” is recommended to be included in clinical practice.
- Hopelessness and distress are connected to experiencing the physician as disengaged, which “support[s] other studies.” “Communication skills training” is recommended.

- An inter-country difference in the assessment of Austrian (“more engaged”) and Italian (“more cold”) physicians is, even if faintly, suggested to be related to “different levels of training in communication skills.” However, we do not get to know whether Austrian physicians are more often trained in “communication skills”!

We thus get to know that many patients with cancer are distressed, that some patients cope better than others, and that it is beneficial to have a communicative doctor. This is something that has long been well known, and adding some new exact percentages or correlations (“more of the same”) hardly does anything to “extend our understanding.” In the absence of an extended understanding, the authors end up simply prescribing the well-known and superficial “darlings” from many correlational studies—“monitoring/screening” and “communication skills training”—and the study concludes with the overall conclusion that “physicians should monitor these variables [emotional distress and maladaptive coping] in their patients and adjust their communication and relational styles accordingly.” This conclusion is most certainly a truism and can in no sense provide us with clinical guidance! The prescription is also problematic as it takes for granted that “monitoring/screening” and “communication skills training” will improve the care of patients with cancer. This is far from self-evident (see, e.g., Merckaert et al., 2010; Moore et al., 2013; Ito et al., 2011; van Scheppingen et al., 2011; Salmon & Young, 2011; Salmon et al., 2015).

When reading Meggiolaro et al.’s (2015) study, a series of papers published in *The Lancet* about a year ago come to mind. One called for increased critical self-reflection in current biomedical research by suggesting improvements in the interest of “increasing value and reducing waste” (Kleinert & Norton, 2014). This series of papers scrutinized different kinds of waste, ranging from unreflected research

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priorities to poor research designs, which result in the absence of a contribution to the accumulation of new knowledge. I do think that their call for reflection is also of relevance for psychosocial oncology.

As researchers in psychosocial oncology, we have a mission to conduct studies that can improve the care of patients with cancer. Purely descriptive correlational studies repeating that cancer implies distress, that some patients cope better than others, and that it is beneficial to have a communicative doctor are not very helpful. We do not need “more of the same.” We do need increased *understanding*, because understanding is a prerequisite to *guiding change*. Before conducting new studies, I think it is a good idea to more critically scrutinize whether the planned design really has the potential to say something more than what is self-evident or is already known, something that can contribute to change—to “increase value.” Just saying what is already known is a waste of time and resources.

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