

Attitudes of Gratitude: An Analysis of 30 Cancer Narratives Published by Leading U.S. Cancer Care Centers

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Abstract—This study examines the ways in which cancer patient narratives are portrayed and framed on the websites of three leading U.S. cancer care centers – The University of Texas MD Anderson Cancer Center in Houston, Memorial Sloan Kettering Cancer Center in New York, and Seattle Cancer Care Alliance. Thirty patient stories, 10 from each cancer center website blog, were analyzed using qualitative and quantitative textual analysis of unstructured data, documenting common themes and other elements of story structure and content. Patient narratives were coded using grounded theory as the basis for conducting emergent qualitative research. As part of a systematic, inductive approach to collecting and analyzing data, recurrent and unique themes were examined and compared in terms of positive and negative framing, patient agency, and institutional praise. All three of these cancer care centers are teaching hospitals, with university affiliations, that emphasize an evidence-based scientific approach to treatment that utilizes the latest research and cutting-edge techniques and technology. The featured cancer stories suggest positive outcomes based on anecdotal narratives as opposed to the science-based treatment models employed by the cancer centers. An analysis of 30 sample stories found skewed representation of the “cancer experience” that emphasizes positive outcomes while minimizing or excluding more negative realities of cancer diagnosis and treatment. The stories also deemphasize patient agency, instead focusing on deference and gratitude toward the cancer care centers, which are cast in the role of savior.

Keywords—Cancer framing, cancer narratives, survivor stories, patient narratives.

I. INTRODUCTION

THIS study examines cancer patient narratives posted to cancer care center websites as blog posts, presented in either first person point of view, testimonial style, or in third person point of view with direct quotes from the patient, similar to journalistic profiles. Specifically, the focus of the study is on dominant narrative frames, which have emerged as a result of textual analysis and subsequent coding. This includes aspects of patient agency versus compliance with medical directives, instances of positive versus negative framing of the cancer experience, and related themes put forward by three of the nation’s leading nonprofit cancer care centers: MD Anderson Cancer Center, Memorial Sloan Kettering Cancer Center, and Seattle Cancer Care Alliance. These three centers have been chosen, in particular, because of their leadership role and influence in the medical industry in terms of cancer care and the

promotional tactics used to achieve and sustain their status.

The central question driving this research is: How are “survivor” narratives used by the nation's leading nonprofit cancer care centers to achieve and sustain the centers' status, and what are the ethical considerations for public relations practitioners?

A primary public relations goal in making use of customer, client, or, in this case, “patient” stories, is to create positive representations of the patient experience, resulting in archetype enactment [1]. Ideally, the goal is for readers with cancer concerns to emulate the story’s “survivor” and to seek out information and, ultimately, treatment from the cancer center featured in the story. Or, if the reader has no immediate cancer concerns, to present a compelling narrative which establishes the cancer care center as the optimal treatment venue should the reader or their loved one require cancer care in the future. In the field of public relations, these narratives, as they appear on organizational blogs integrated with the corresponding websites, serve as a form of “controlled media,” meaning public relations material generated directly by the organization without making use of an objective intermediary, such as a journalist, to reach their target audiences. This is a form of subjective messaging, shaped and controlled by the public relations practitioner, although the narratives are presented as “true” stories of individual experiences with cancer without reference to editorial considerations or the process by which these stories were collected and constructed.

The PR objective, to persuade a reader to reach a certain conclusion benefitting the organization, is achieved by relying on the reader’s induction reasoning, aiming for those inferences that will be made based on a compelling, provocative story that facts alone would not elicit. The power of the narrative upon memory and understanding has been topic of inquiry for psychologists, neuroscientists, communication studies, media theorists and those who study reading comprehension — the general conclusion being that story form is particularly powerful for a variety of reasons, including either identification with the subject or, if not identifying, being “transported into the narrative,” with targeted attention on the events of the story even without identifying with the protagonist [2]. Furthermore, PR researcher Terrence Flynn suggests that the use of narrative is particularly powerful in health communications as a means to combat resistance to messaging. “When dealing with health-

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related, behavioral change messages, many individuals respond with resistance to the recommended change. One potential method to overcome resistance is through the development of narrative-based, persuasive communications – in popular terms this is often called ‘storytelling’ [3].

In a paper on the “usefulness of narratives” published in *Annals of Behavioral Medicine*, researchers explore ways in which stories from others can be used to promote better health experience — from changing attitudes to making better medical decisions — recognizing the power inherent in making use of such narratives in a medical setting, “Stories about health outcomes can be comforting (particularly when the outcome is positive), but the most noteworthy effect of outcome narratives is their ability to be persuasive, changing attitudes and altering intentions and health behavior” [4].

In “Using narratives and storytelling to communicate science with non-expert audiences,” Michael Dahlstrom distinguishes the narrative structure as having “cause-and-effect-relationships between events that take place over a particular time period that impact particular characters.” Further defining this particular form of writing, he states that such narratives can include “testimonials, exemplars, case studies, or eyewitness accounts.” Dahlstrom’s conclusion is that scientific communication that is logical relies on accuracy to be perceived as legitimate; however, narrative, in providing “a reasonable depiction of individual experiences,” is judged on “the verisimilitude of its situation” [5]. Indeed, the power of the patient’s story is directly related to the reader’s perception. In an article written for *The Journal of Neuroscience*, “The Storytelling brain: How Neuroscience Stories Help Bridge the Gap Between Research and Society,” the authors echo this sentiment, stating, “Storytelling, engages not just people’s intellect, but also their feelings: a bald recitation of facts invariably lacks the impact (and the enduring power) of a coherent narrative that awakens one’s emotions. Indeed, when major discoveries generate little interest among the lay public, there is likely a disconnect between the scientific content and its emotional impact” [6].

In describing the power of storytelling related to public health perceptions and behaviors, researchers from the Institute of Health Informatics at University College London, drawing in part from findings related to smoking cessation conducted by medical researchers, note that influence of the narrative is related to the relationships it fosters, stating, “Storytelling potentially draws on commonalities between the story or the storyteller and the listener or reader. This, combined with the underlying assumption of credibility in the teller’s story or experience, can potentially motivate and persuade individuals towards behavioural change and reduces resistance to any action implied by the message” [7]. Researchers from Radboud University’s Center for Language Studies in the Netherlands also explore the persuasive powers of narrative structure in their examination of “hero enactment” [1]. In short, the hero’s journey includes three distinct phases: “the departure,” “the initiation,” and “the return.” For the individual at the center of the cancer story, the departure, where one encounters “forces that are not rightly understood,” parallels initial discovery and

diagnosis, which is positioned as the obstacle the narrator must find a means of defeating in order to survive. The “initiation” stage occurs when the narrator — still on their journey — confronts their obstacles and receives treatment. (In the mythical version, the hero would receive the amulet, or magic potion to gain power to overcome the obstacle.) Lastly, the hero returns from the journey transformed, often to such an extent they have the power to transform others. In the cancer patient’s story, the return is recovery and re-entry, but they are always in some ways transformed by the experience, whether that be mentally, physically, spiritually, or some combination of all three. The implicit expectation being that their story empowers and emboldens others on the “journey.” Referring again to Jung’s theory of archetypes and Campbell’s theory of the “hero’s journey,” the authors postulate that the audience members for these stories are attracted to them not only due to the cathartic nature, but because of the similarity to life cycle. “The concepts developed in their work (Jung and Campbell) are nevertheless useful in understanding why people are naturally attracted to stories: their generic template shows similarities with the life cycle of individuals. Like the Hero in a narrative, individuals undergo transitional stages in their lives. These include changes resulting from life experiences...” [1].

Under consideration and underlying this analysis is the Public Relations Society of America’s professional values, which outline ethical guidelines for organizational communicators as a “professional code of conduct.” Of the six provisions, the “Loyalty” provision addresses the need to not only serve the client, but also the public interest, “We are faithful to those we represent, while honoring our obligation to serve the public” [8]. Thus, in the field of health communication, this provision dictates that public relations specialists perform tasks in a manner that not only benefits the organization, but public welfare.

II. METHODOLOGY

A. Textual Analysis & Primary Source Interviews

Research methodology employed in this study includes close readings of 30 “survivor stories,” cancer patient narratives. This includes performing a textual analysis through coding patient narratives using grounded theory as the basis for conducting emergent qualitative research. While greater attention is given to components of qualitative analysis, quantitative analysis has been employed to account for recurrence of themes and the repetition of certain descriptors and phrasings that serve to frame the patient cancer experience. The most common descriptive positive and negative terms used in the 30 narratives were coded for and documented. In addition, cancer patient positionings within the narratives — as occupying subject or object positions — were studied, quantifying instances when the cancer patient either took action, or was acted upon, within the arc of each story.

As part of the systematic, inductive approach to collecting and analyzing data, the story structure was analyzed, focusing on elements of persuasion and the extent to which the stories follow the traditional story arc. In addition, instances of patient

as actor (patient positioned as subject) and patient as acted upon (patient positioned as object) were documented and analyzed. Cancer patient experiences were coded for positive and negative framing to document the usage of specific positive/negative descriptors and, to some extent, phrases found in each testimonial. Corollary findings were documented related to cancer care, prevention, and lifestyle, noting information most commonly included in addition to details conspicuously left out.

As part of this analysis, one in-field interview with a public information officer at one of the three corresponding cancer care centers was conducted regarding what they perceive as the goal of their patient narratives, ethical considerations related to the construction and content of the narratives, and their criteria for choosing which stories and individuals are to be featured on their organization websites. Questions posed included the topic of decision making related to details included and excluded in telling the cancer “survivor” stories featured on their website.

B. Sample Size & Content

A systematic sampling method was used to randomize the narratives, drawing from the last 10 recently posted narratives from each of the three cancer care center blogsites – irrespective of the cancer patient profiled, the type of cancer represented, or the outcome. This resulted in examining 30 narratives, in all, from 2019-2020. The only exception made was to dismiss one narrative that did not address the expanse of the cancer experience in a manner similar to the other narratives, but, instead, aimed to detail the experience of returning to the hospital for treatment following the onset of the pandemic and the safety measures imposed. As this narrative reflected a significant departure from the other cancer narratives, with an apparently different public relations goal, it was intentionally left out of the study. Again, the three cancer care centers that are the focus of this research are influential leaders in the field, typically rated among the top ten in cancer care. All three are university affiliated and considered research institutions. Also, collectively they represent three distinct regions of the U.S. – the Pacific Northwest, the South, and the Northeast – allowing for a study that represents a wide swatch of the country while keeping the sample size manageable.

III. LITERATURE REVIEW

As cancer is a common affliction, it is not surprising to find a vast and diverse spectrum of health communication scholarship that centers on everything from branding the cancer narrative in memoir form, to the use of war and battle metaphors in communications related to cancer, to the impact of personal narratives as an effective persuasive strategy in the field of public relations. Such research is generated by academics from a variety of disciplines, including, but not limited to, psychology, communication studies, sociology, anthropology, business, and health and human development.

Previous research has included an examination, from a behavioral science perspective, of the effectiveness of personal narratives as a persuasive public relations tool. In a 2015 paper by public relations scholar Dr. Terrence Flynn, “How

Narratives Can Reduce Resistance and Change Attitudes: Insights from Behavioral Science Can Enhance Public Relations Research and Practice,” the author explains the power of narratives — storytelling in health communications in particular — to create change in behavior and action while not addressing underlying issues in the attempt to simplify the problem [3]. In a paper that more specifically addresses cancer narratives, psychology professor Melanie C. Green, looks, fairly favorably, at the primary mechanism of narrative persuasion as an effective strategy for changing beliefs, motivating action, and conveying cancer information due to both the persuasive structure of storytelling to limit counter arguments and the role modeling generated by the featured narrator [9].

With a focus on cancer “illness stories,” Professor Judy Z. Segal critically examines cancer stories she received as reader responses to an op-ed she wrote for the Vancouver Sun, “Cancer Isn’t the Best Thing that Ever Happened to Me,” about how we talk about cancer. In doing so, she also writes about the problematic coercive elements of cancer narratives designed to induce positive thinking, taking into consideration an array of published cancer stories, especially those that take on the topic of breast cancer [10].

In regard to branding and narrative structure as it is used to persuade consumers, psychology professor José Sanders and linguistic professor Kobie van Krieken examine story structure in “brand stories,” essentially advertisements, finding that the central power of the narrative is in creating a strong relationship between the consumer and the brand, linking their identities [1]. Psychology professor David Hauser examines the use of war metaphors in addressing cancer, with his conclusion evident in the title of their paper, “War on Prevention II: Battle Metaphors Undermine Cancer Treatment and Prevention and Do Not Increase Vigilance.” Thus, it is Hauser’s observation, based on four studies conducted with participants reading cancer “profiles” — some containing war metaphors and some without — that his evidence shows profiles featuring war metaphors led to more fatalistic beliefs about cancer outcomes without promoting vigilance and monitoring, a negative health effect [11].

Despite an abundance of research related to the power and limitations of personal narratives, very little study has focused specifically on cancer “survivor” stories used as a form of public relations that takes into consideration story structure and language. Furthermore, it is rare to find research in this area that includes primary source interviews with PR practitioners to help contextualize and explain the PR strategies involved in featuring cancer stories on cancer center websites. This research builds upon the extensive scholarship related to personal narratives, while adding focus to existing scholarship on cancer-related communication and branding.

IV. FINDINGS

A. Cancer Story Framing: Positive vs. Negative Terminology

Although cancer can be life threatening, and the majority of the 30 narratives in this study featured particularly challenging

or advanced cancers, findings show that the patient stories skewed toward positive framing of events at more than twice the rate of negative framing. This framing conflicts with studies of cancer patient responses to their diagnosis and prognosis. In 2019, Italian researchers from the University of Milan and the European Institute of Oncology studied the roles of fear, anxiety and worry in relationship to cancer patient decision making. In their meta-analysis of 39 separate studies, they found that cancer diagnosis and prognosis elicit negative emotions that can impact patient decisions about treatment plans and personal health decisions. “Negative emotions elicited by the new (negative) situation often means that attention is focused on the negative aspects, producing a distortion in risk perception and, consequently, suboptimal health decisions” [12].

In a study of the emotions of patients with advanced cancer, drawing from the fields of psychology and clinical communications, researchers from Weill Cornell Medicine and Memorial Sloan Kettering in New York found that common emotional responses to discussions of poor prognosis, such as advanced cancer, include sadness, anxiety, anger, shock or numbness. While it is not surprising that patients with advanced cancer would react negatively to poor prognoses, the New York researchers emphasized the importance of engaging with negative emotions to help patients process their reactions and stay active and engaged in end-of-life planning. “Accordingly, the presence of negative emotion does not indicate that a visit has gone awry. Rather, these reactions may indicate patients are attempting to make sense of the information that was conveyed, and can foster meaningful interactions between clinicians and patients.” In the same 2019 study, researchers also note that the emotional reactions of patients with advanced cancer are complex and, even in the case of a poor prognosis, positive framing by patients should be recognized by clinicians as a potential coping mechanism or in relation to family or cultural expectations. “Patients also engage in efforts to change or manage their own emotions, either pre-emptively or in response to bad news” [13].

In analyzing the 30 narratives included as part of this research study, terms (verbs, nouns, adjectives) that served to describe the cancer patients’ experiences were coded for contextualized negative and positive denotation and/or connotations. After listing the positive and negative terms derived from all 30 narratives, numerical sums were tallied to provide comparative totals of positive versus negative terminology. The terms chosen were determined by noting every positive or negative framing term found overall. Sums were determined from conducting document word searches followed by verifying if the term was used in a positive or negative context. For example, if the word *regret* was used in the positive, “She had no regrets,” it was not counted as a negative usage in those instances, but it was counted as positive usage as part of the phrase, “no regrets.”

As Fig. 1 shows, positive framing terms outpace negative framing terms by more than 2:1 with 112 positive terms and 50 negative terms in the 30 narratives. The most used positive framing term was the word “hope” (and its variations,

“hopeful” and “hoping”) which was found 29 times among the three cancer care centers. Positive framing expressing gratitude, mostly directed toward the cancer care center and its team of doctors included “thank” (and its variations: thanks, thankful, and thankfully) which appeared a dozen times, and the similar term, “grateful,” appeared seven times. Patients were also portrayed as both upbeat about their treatment and optimistic about their prospects moving forward. The term “success” or “successful” occurred seven times in the narratives and “happy” was repeated nine times. Patients expressed relief, with the words “relief” or “relieved” appearing five times, as well as a determination to stay positive as well as hopeful — “stay/ing positive” was mentioned in nine of the narratives. There were three uses of the word “lucky” and three uses of “thrive/thriving.” There were two instances of “no regrets,” and two uses of “journey,” as in “cancer journey.” Because “journey” may be considered a more neutral term than overtly positive, it was not included in the final tabulations.

28 terms conveying positive and negative framing attributes of the patients’ cancers were identified – 14 positive and 14 negative — which appeared a total of 162 times. Negative framing terms, shown in Fig. 2, were less frequently included, appearing at less than one-third the rate, 31% of the 162 inclusions, with positive framing terms accounting for 69%, as shown in Fig. 3. The most often used negative term was “shocked” (and its variations, “shock” and “shocking”), appearing in 10 instances in 30 narratives. The next term, which was typically included to express the dire nature of the cancer, and, thus, a negative, was “advanced cancer,” which was included eight times. In most of these instances, however, the fact that the cancer was advanced (a negative aspect) was used to reinforce a positive, that the patient survived treatment and was now living “cancer free.” Terms other researchers have cited as common reactions to diagnosis or prognosis appeared less often. For example, the terms “anger,” “anxiety” or “regret,” were not found as negative frames in any of the narratives. “Sad” appeared twice, while “scared” appeared only once, with “fear” and “fearful” appearing a total of three times throughout. “Die,” “death,” and “dying” appeared infrequently as well, with only three mentions of death, such as, “In our culture, we equate cancer with death” [14], and, “I was afraid I was going to die” [15].

Instances of Agency: Patients as Narrative Subjects or Objects

In examining instances of the subjects’ agency — meaning instances when the cancer patients are depicted as acting of their own volition, or participating in any form of action, versus descriptions of being acted upon (by medical staff or others) — the depictions of patient agency in these 30 narratives were significantly less for all three cancer care centers:

- Seattle Cancer Care Alliance = 43 instances of agency/action versus 64 instances of the patient being acted upon.
- Memorial Sloan Kettering Cancer Center = 23 instances of agency/action versus 92 instances of patient being acted upon
- MD Anderson Cancer Center = 47 instances of agency/action versus 87 instances of patient being acted upon.

Positive Framing Terminology Most Frequently Used in Cancer Patient Stories

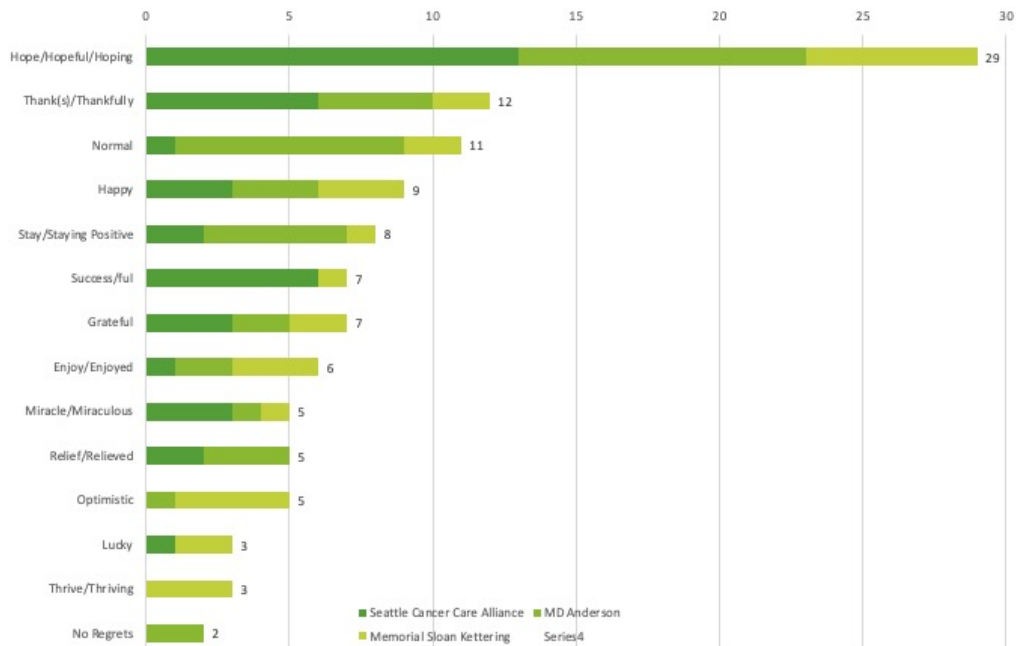


Fig. 1 The most commonly used positive descriptors from a sampling of 30 cancer patient narratives featured on the cancer care center blogs of Memorial Sloan Kettering, MD Anderson Cancer Center and Seattle Cancer Care Alliance

Negative Framing Terminology Most Frequently Used in Cancer Patient Stories

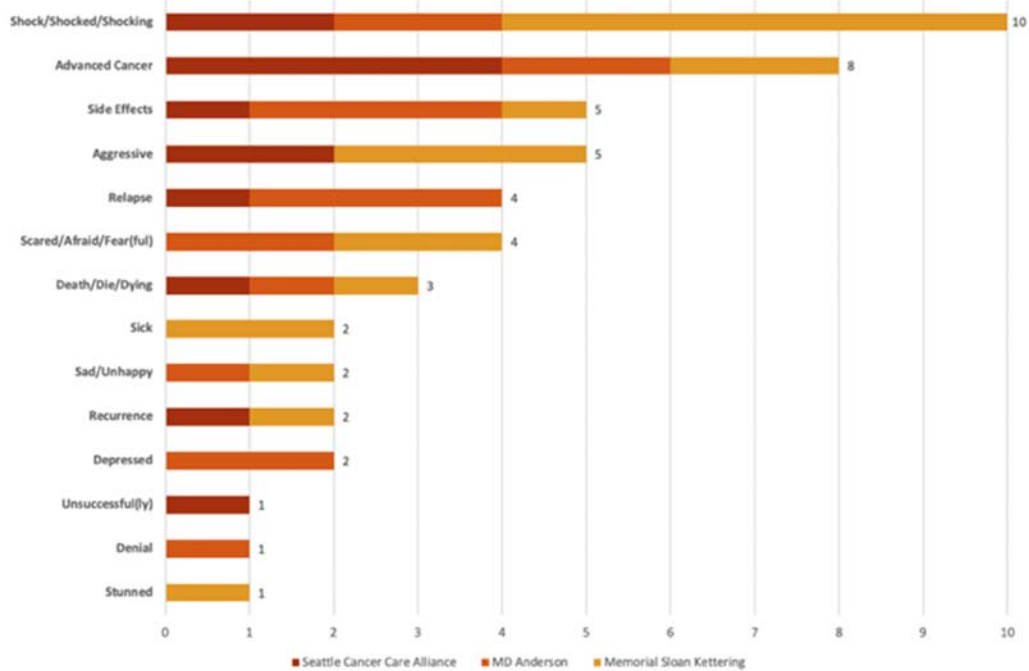


Fig. 2 The most commonly used negative descriptors from a sampling of 30 cancer patient narratives featured on the cancer care center blogs of Memorial Sloan Kettering, MD Anderson Cancer Center and Seattle Cancer Care Alliance

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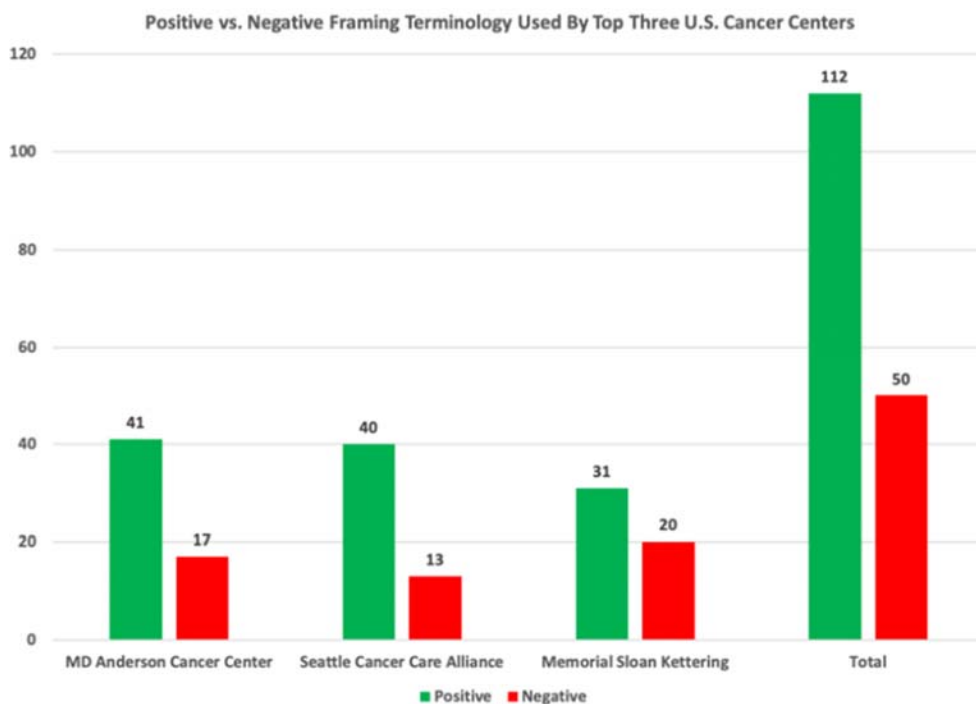


Fig. 3 Comparison of the use of positive and negative descriptors from a sampling of 30 cancer patient narratives featured on the cancer care center blogs of Memorial Sloan Kettering, MD Anderson Cancer Center and Seattle Cancer Care Alliance

In total, from the 30 difference cancer stories included as part of this study, the results showed 113 instances of patients acting of their own volition versus 243 instances of being acted upon, at a ratio of nearly 2:1, see Fig. 4. Coding for examples of agency included identifying acts of decision making by patients related to their cancer treatment or other decisions, such as choosing to rent an apartment near the hospital where they were receiving treatment, participating in exercise, seeking a second opinion, joining a writers' group, composing music, etc. For example, "And to cope with the pain, I enjoy journaling. It helps me to distract myself and find clarity" [16].

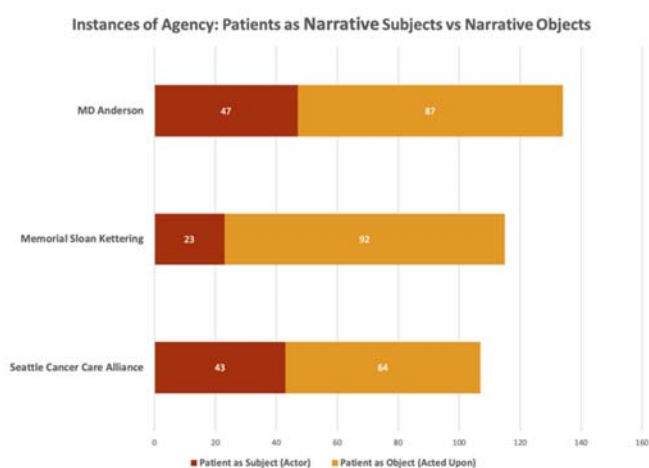


Fig. 4 Instances of the subjects' agency versus instances in which the subjects are being acted upon from a sampling of 30 cancer patient narratives featured on the cancer care center blogs of Memorial Sloan Kettering, MD Anderson Cancer Center and Seattle Cancer Care Alliance

Other examples of cancer patients expressing agency included instances of taking their care into their own hands. However, such instances typically referred to medical experiences or exchanges patients had prior to entering the cancer care center that would eventually successfully treat them and later publish (and publicize) their story. For example, a patient who would eventually be diagnosed with ovarian cancer and seek care at Memorial Sloan Kettering, expressed frustration with a gynecologist she saw prior to her cancer diagnosis, "Months later, she still wasn't feeling well, but her doctor told her not to worry. Finally, in October 2015, Haley insisted on an ultrasound. The scan picked up a mass in her abdomen" [17]. Even when patients showed agency, decisions were emphasized that led them to the care of the cancer professionals who would then take control, treat their cancer and save their lives.

Instances where the patient was the object of an action, including instances or events in which their participation was not described as a choice, or when the cancer care center and/or its medical staff was cast as the subject, with the patient in the role of object, included medical actions taken upon the patient (i.e. surgery, chemotherapy, radiation, medical testing) and acts of patient care in general. For example, "Marc's internist told him: 'It's renal cell cancer, and you're going to SCCA on Monday.' Marc's SCCA team moved quickly to begin his treatment" [18].

Coding for instances when the cancer care center is cast in the role of subject/actor included a subcategory where, in direct quotes from a patient, or sometimes paraphrasing sentiment expressed, praise was given for the cancer care center and/or medical staff with emphasis on actions taken on the patient's behalf, typically expressing deference. For example, "MD

Andersen has saved my life over and over these last nine years” [19]. A cancer patient at Memorial Sloan Kettering, referring to one of her doctors there, was quoted as saying, “‘She gave me tough love,’ Elizabeth recalls. She said, ‘This isn’t a common cold. This is cancer that needs to be treated aggressively’” [20].

B. In-Field Interview: The PR Practitioner’s Perspective

As part of this study, cancer care center public relations staff were contacted and requests for interviews were communicated by phone message and via email following IRB protocol informed consent. The response, however, conveyed a lack of interest, or, possibly, reluctance by two of the three communication offices contacted. One cancer center declined to participate, one did not respond to repeated requests, and a third agreed with awareness participation would be anonymous. While only a single interview was conducted, and, therefore, commentary cannot be considered representative of communication strategies employed by all three centers (or, by extension, cancer care centers at large), the results of the single primary-source interview was germane to the text-based findings. The interviewee explained what factors determine which patient stories are considered for development and, ultimately, publication and how those decisions relate to the cancer center’s promotional goals. For example, how the story may be received on social media has an influence upon whether a story is featured. The interviewee said at the cancer center where she works one criterion for inclusion of a specific patient’s narrative may be that one of the center’s doctors is conducting a clinical trial they want to promote, or a staff member may want to promote a special program through a patient’s story, or someone may think a patient’s story is particularly unique or compelling. Other times patients may offer their story up to be featured themselves. Regardless, patients who are being considered go through a vetting process to determine whether they are in good standing, financially, with the cancer care center, that they have not publicly complained about the center or associated staff on social media, and that they are emotionally stable enough not to be somehow triggered when their story is featured.

The interviewee said she intends for “survivor” narratives to serve a usefulness for readers, whether the reader intends to seek treatment at the cancer care center or if they had a relative or friend with cancer. However, the interviewee also said another goal was to attract patients to the cancer care center through their identification with the patient at the center of the story, or through their emotional engagement with the story itself as a compelling narrative regardless of identification. In that manner, the patient story may be memorable enough to keep the cancer care center in mind should the reader, or someone they know, seek cancer treatment in the future. “I think, at the end of the day, people like feeling like they’re reading something from a friend, having a conversation with a friend. And that’s something we have heard, a lot, anecdotally, from people who say, ‘I’d never met anybody before who had my type of cancer. I’d never heard of anybody who had my type of cancer. And then I found your story, and now I know what I’m going to talk to my doctor about.’”

While the interviewee acknowledged that not all readers of the blogpost may have the insurance coverage to meet the cost of the cancer care they offer, or may not be able to afford to travel for treatment, the intention is that there is something in every story for everyone, some value, with the “ultimate goal for people to request an appointment, or to donate, but usually it’s to request an appointment.” Moreover, the interviewee explained how the stories serve define the organization and set the tone. “We want to raise brand awareness. These stories are our stories. They’re stories of people who come to [name of cancer care center] and have some level of success. That doesn’t necessarily mean they’re in remission, or ever will be in remission, but they are willing to share their story. They become an ambassador.”

C. Corollary Findings

In addition to evidentiary findings revealed through conducting close readings of the cancer “survivor” narratives, observational findings include more subtle results, specifically consistently missing elements that are typically part of the cancer experience. Especially conspicuous was the lack of references to probable causes of individual cancers. With the exception of one of the narratives, none of the other 29 patient stories included a reference to the cause, or potential cause, of their cancer, including, even, casually questioning its origin. The only exception to this was a cancer patient with Cowden Syndrome who had experienced multiple cancers as the result of having a rare disease which causes a proliferation of both benign and cancerous growths due to a gene mutation that prompts rapid cellular division. Other missing or rarely mentioned elements include cancer preventative actions, prognosis and treatment side effects. Given that between 30 and 50% of cancer deaths are the result of five behavioral risks (body mass index, low fruit and vegetable intake, lack of physical activity and tobacco and alcohol use) it would stand to reason that a reference to lifestyle would be part of the cancer experience patients describe [21]. Because all three of these cancer care centers provide integrative medicine as part of cancer care either electively or prescriptively, it would also stand to reason that information related to lifestyle be more commonly included in their featured cancer narratives. Of the 30 narratives examined, only one mentioned exercise prescribed as part of a cancer treatment regime. Two others mentioned engaging in a bike race to raise money for cancer, one of which described training for the event. A few stories included exercise as part of their normal pre-cancer routine to which they were returning, but not in relationship to staving off a relapse or healing from cancer. None of the narratives noted the significance of diet. There were a few references to social support of loved ones as well as references to activities that reduced stress, but there were no direct links made between these activities and their potential health benefits. There were also no mentions of life expectancy or survival rates related to the particular cancers, with the exception of those that were dispensed by a previous doctor and, later, disproven by the superior treatment provided by the cancer care center they sought out (either MSK, MDA, or SCCA). Lastly, there were

very few references to treatment side effects, although side effects are, in general, part and parcel of cancer treatment. It should be noted, however, that these findings – having only examined 30 narratives in total — are not exhaustive. Additional narratives gathered from a wider selection of cancer care centers could be considered as part of a more expansive study.

V. INTERPRETATION OF FINDINGS

This study and findings at the center of this paper show that cancer care center “survivor stories” are not utilized as a medium to deliver cancer facts related to prevention and outcomes. Moreover, the narratives deemphasize the hardships of cancer, treatment side effects, and/or the patients’ role in seeking beneficial lifestyle choices. Instead, greater emphasis is placed on the triumph of survival by which the treatment center, in the savior role, enables the patient’s success, represented as a cathartic medical journey, rendering them the “survivor,” the prized conclusion. For readers interested in cancer care, but not afflicted, these narratives may work similarly, to generate confidence in the organization’s ability to “cure” cancer. (Of course, as these are “survivor” stories, none include death as an outcome, although the reality is that not all cancer patients survive, even those treated at the nation’s top cancer centers.)

At stake are the ways in which cancer care center promotional materials —specifically, in this case, the “survivor” narratives — shape perceptions and understanding of various cancers, as well as expectations for cancer care and cures, in an attempt to achieve promotional goals. The featured patient stories could be perceived as contradicting the evidence-based model that serves as the basis for care at the three cancer centers, as the patient stories are not an accurate representation of scientific outcomes related to developing cancer, cancer reoccurrence or cancer outcomes (survival). There is an inherent risk that readers will view these narratives as evidential, when in fact they are unique examples that demonstrate only one person's experience. As a result, such narratives may contribute to creating inaccurate notions of cancer prevention, cancer care treatment and the potential for a cure, while influencing beliefs that have impact on choices made by patients, providers, and, in terms of the collective impact of communications beyond the three centers examined, society at large.

VI. CONCLUSIONS

While it is not surprising that cancer narratives promoted by three top cancer care centers would be framed as a positive experience, these happy and hopeful testimonials should be viewed in the context of research that demonstrates the negative emotions elicited from cancer diagnoses and treatment. The positive framing of cancer patient testimonials also raises fundamental ethical questions of whether the nation’s top cancer care centers are purposefully minimizing negative outcomes and emotions in patient narratives directed toward the public, their potential customers.

VII. LIMITATIONS

This study was limited in scope, examining 30 narratives in total — 10 from each cancer care center within a limited timeframe. As a result, further study and examination of additional cancer story blog posts is warranted to more fully explore the breadth and scope of emergent themes documented in this initial analysis. Another limitation may be that the cancer patients themselves are inclined to positively frame their experience, either as a coping mechanism or as an act of gratitude toward their chosen cancer center, which has requested to hear/share their story. Furthermore, it is difficult to determine, without reading the raw interview transcripts, what content has been left in and what has been left out by the writer and/or editor. Without access to the cancer story transcripts, it also is impossible to know how the interview process itself shaped the patient responses that resulted in the published blog post. Further research that included access to complete manuscripts and compared those with the published patient narratives would be illuminating in this regard.

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