Translating Cancer Science Into Cancer Care: Using Serious Illness Communication Frameworks to Deliver High-Quality Person-Centered Care in Neuro-Oncology

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OVERVIEW

People with CNS cancer and their caregivers need and deserve not only innovative cancer-directed care but also high-quality person-centered care for navigating living their lives in the face of their cancer diagnosis and treatment. Palliative care aims to be an extra layer of support for people with cancer and their caregivers by focusing on what matters most to them and helping people live as well as they can for as long as they can. Palliative care is appropriate starting from time of diagnosis when many palliative care needs begin and is most beneficial when integrated earlier in the disease trajectory, yet the provision of palliative care remains underutilized in neuro-oncology. Centered on illness experience and the multidimensional composition of a person's biological, psychological, and social factors, palliative care is an approach to person-centered care focused on optimizing management of distress arising from physical, psychological, social, existential, and spiritual concerns to reduce and mitigate suffering while promoting coping, patient autonomy, choice, and access to information per the values, goals, priorities, beliefs, and culture of the patient, caregiver, and family members. Fundamental aspects of palliative care, referred to as primary palliative care, should be provided by all clinicians, with specialty palliative care clinicians augmenting as needed where available. In this article, teachable, learnable, and adaptable serious illness communication frameworks leveraged in the palliative care approach are featured in two vignettes. The use of these serious illness communication frameworks actualizes the translation of cancer science into high-quality person-centered cancer care.

OVERVIEW

In this article the underutilized provision of palliative care as an extra layer of support for people with CNS cancer and their caregivers, which focuses on optimizing quality of life through managing and mitigating distress and suffering, is explored including a brief discussion of the biomedical versus biopsychosocial models of medicine and concept of total pain. In addition primary palliative care (PPC) versus specialty palliative care (SPC) is outlined and serious illness communication frameworks are featured within two clinical vignettes; a middle-age man diagnosed with glioblastoma whose wife wants to know different information from the neuro-oncology team than the patient and a teacher in the adolescent and young adult (AYA) age range diagnosed with a low-grade glioma who is experiencing social and existential distress in conceptualizing her uncertain future. The vignettes demonstrate how these serious illness communication frameworks actualize the translation of cancer science into high-quality person-centered cancer care.

> Vignette 1: David is a 58-year-old retired engineer diagnosed with glioblastoma six weeks ago following a seizure at home. He has undergone surgical resection and is midway through 6-weeks of concurrent radiotherapy and temozolomide. His wife, Carol, attends every appointment. David is quiet during consultations, deflecting questions with dark humor. Carol emails the clinical nurse specialist between appointments with detailed questions about prognosis, recurrence rates, and what the end will look like.
>
> The neuro-oncology team is experienced, but the dynamic is becoming strained as David doesn't want to discuss prognosis, yet Carol is desperate for information so that she can plan, making sure that she has everything in place for what lies ahead. The clinicians feel caught between them.

INTEGRATING MODELS OF MEDICINE IMPROVES OUTCOMES

Western medicine, including modern oncology with its continuously evolving scientific advances in cancer-directed treatment, is based on the biomedical model which considers health to be the absence of disease. The

PRACTICAL APPLICATIONS

- Palliative care is a person-centered approach that aims to optimize management of distress arising from physical, psychological, social, spiritual, and existential concerns while supporting the individual's needs, values, priorities, beliefs, culture, autonomy, and access to health care information and choice, delivered concurrently with cancer-directed care.
- People with CNS cancer and their caregivers often have unmet palliative care needs from the time of diagnosis.
- Palliative care is appropriate at any stage in the disease trajectory with people living with CNS cancer and their caregivers benefiting sooner when palliative care is integrated earlier.
- Primary palliative care (PPC) provided by oncology teams entails basic symptom management, discussions about code status, health care surrogate designation, prognosis, treatment intent, and timely referral to hospice.
- Specialty palliative care clinicians who have expertise in serious illness communication augment PPC for those patients and caregivers who have palliative care needs such as high and/or complex symptom burden; moderate to severe distress arising from social, emotional, spiritual, and/or existential concerns; conflicts between or among patient/caregiver/family members/health care staff; and complex hospice transitions.

biomedical model of medicine is centered on disease: elucidating its pathophysiology and risk factors and identifying how it can be diagnosed and treated. Inherent in biomedical medicine is the premise that elimination or attenuation of the disease results in restoration of health. In contradistinction to the biomedical model's disease-focused medicine, the focus of the biopsychosocial model of medicine is improving how a person living with an illness feels and functions. The biopsychosocial model is centered on the illness experience and its multidimensional phenomenology that arises from an individual's unique biological, psychological, and social factors (Fig 1).[1] Examples of health care specialties informed by the biopsychosocial model include palliative medicine, physical and rehabilitation medicine, nursing, and psychology. They aim to optimize how people diagnosed with disease are feeling and functioning within the context of their unique individual illness experience harmonized with their disease-directed treatment.

People with cancer and their caregivers need and deserve the biomedical and biopsychosocial models of medicine delivered concurrently within their comprehensive cancer care to have the best possible outcomes for their cancer and their lives. Given the incurable nature of many primary and secondary cancers involving the CNS, palliative-intent cancer-directed treatment aims to slow disease progression, prolong survival, reduce disease symptoms, and maintain quality of life. Yet, people with CNS cancer and their caregivers have expressed wanting support for emotional distress, social and relationship issues, existential concerns, coping with uncertainty and neurobehavioral changes, and navigating health care in addition to cancer-directed treatment.[2] AYAs, including those with CNS cancer, might also have unmet symptom control and psychosocial and spiritual needs. Many express wanting care focused on palliation and quality of life aligned with palliative care especially late in the disease course.[3,4] Palliative care is an approach to person-centered care focused on optimizing symptom control, addressing informational needs and multidimensional suffering according to the beliefs, culture, values, goals, and priorities of the person with serious illness and their caregiver.[5] Suffering may not be limited to physical symptoms. Suffering may arise from psychological distress and loss or change of social roles. Suffering may also encompass existential and/or spiritual concerns. The combination of all these factors related to suffering was conceptualized as total pain by Cicely Saunders (Fig 2).[6] Given that suffering may arise throughout the disease trajectory and not only at the end of life, palliative care is appropriate at any time starting from diagnosis concurrent with cancer-directed treatment. This approach is especially crucial for people with CNS tumors.

Robust evidence from randomized trials investigating palliative care for people with advanced cancer concurrent with cancer-directed care resulted in ASCO and multiple other professional organizations issuing guidelines or recommendations for concurrent palliative care as the standard of care for patients with advanced cancer (Table 1).[5,7-10,14,15] Guidelines specifically addressing the role of palliative care for adults with CNS cancer include the National Comprehensive Cancer Network (NCCN) and the European Association for Neuro-Oncology (EANO).[5,8] EANO designated three main areas of palliative care for adults with glioma: symptom management, patient and caregiver needs, and palliative care including but not limited to care in the end-of-life phase and provides concrete clinical and management interventions.[8] The National Institute of Health and Care Excellence (NICE) issued committee-level recommendations on the diagnosis and management of primary brain tumors and brain metastases and determined that people with brain tumors have very specific needs that are often not met and issue guidance on improving supportive and palliative care for adults with brain cancer.[9] The NCCN CNS tumor panel recommends that "palliative and pain management should be integrated into management of neuro-oncology patients early in the course of their treatment."[10] A

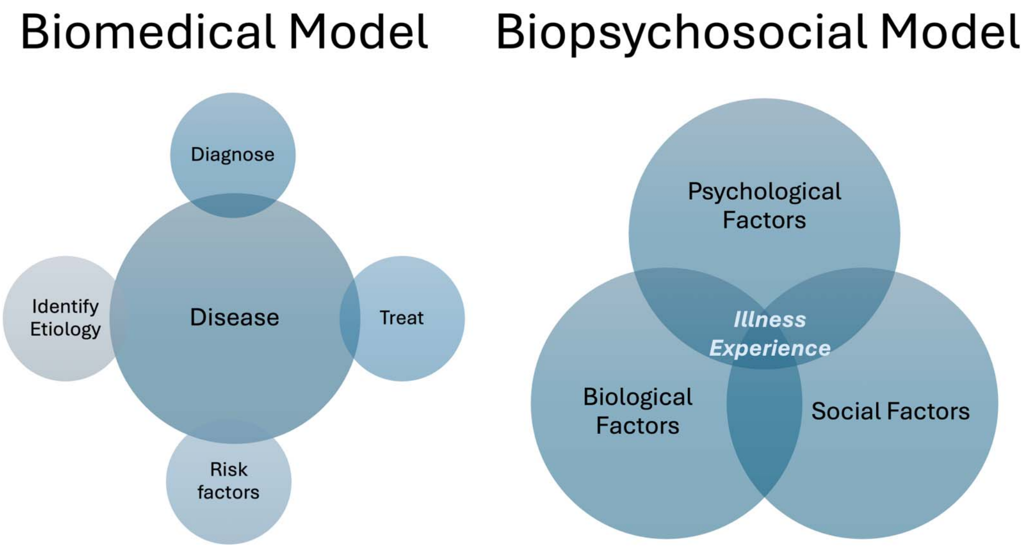

FIG 1. Comparison of the biomedical model of medicine focused on disease and the biopsychosocial model of medicine focused on the illness experience.

recently published prospective randomized trial evaluating early palliative care for adults with glioblastoma provides evidence that early palliative care integration improves quality of life, mood, communication, and coping with neurologic functions among surviving participants.[16] Overall, SPC consultations are underutilized for people with primary brain tumors.[17] Underlying factors range from neurocognitive dysfunction, psychiatric and behavioral changes from time of diagnosis, limiting communication and engagement in serious illness communication, to avoidant coping strategies such as denial, and the prevailing misconception among clinicians, patients, and caregivers alike that palliative care is only for people who are at end of life or is synonymous for hospice care.[18-20]

All oncology clinicians should provide palliative care, often referred to as "primary" palliative care, in collaboration with SPC experts per evidence-based guideline cancer care pathways and based on based patients' palliative care needs. NCCN recommends that all patients with cancer should be screened for palliative care needs at their initial clinic visit and at subsequent visits as clinically indicated, and ASCO recommends early engagement in palliative care for adults with advanced cance.[5,7] In addition to people with cancer themselves, their caregivers and family members should also be informed that palliative care is an integral part of comprehensive cancer care from time of diagnosis and palliative care provides an extra layer of support, reinforcing the message that it is not end-of-life care. Vierhout et al

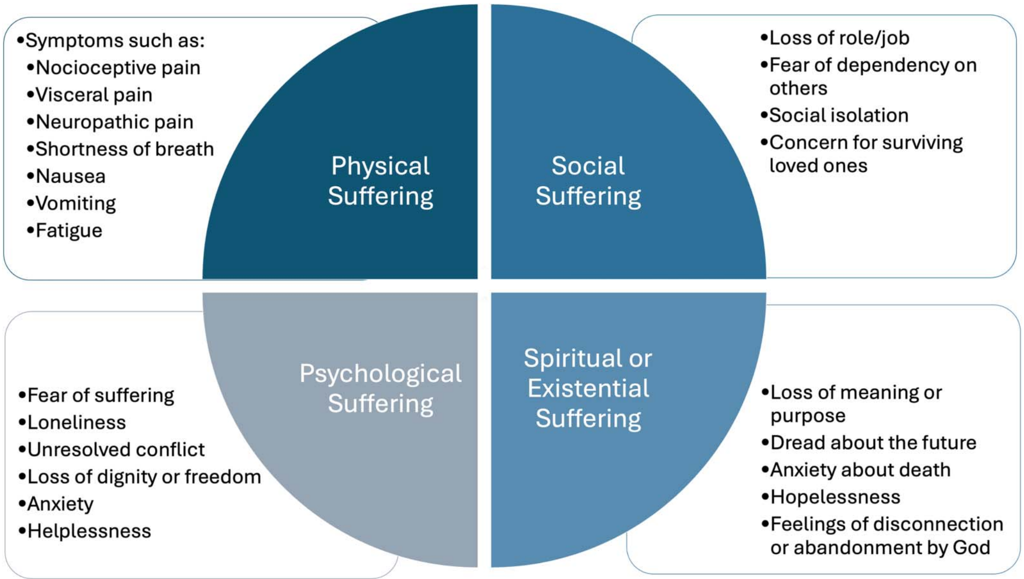

FIG 2. Concept of total pain as first described by Dame Cicely Saunders.

TABLE 1. Professional Organizations With Issued PC Guidelines or Recommendations

Organization	Guideline Specifically Addresses PC for People with CNS Cancer (Y/N)	Summary of Recommendations
American Society for Clinical Oncology (ASCO)[7]	N	Formal guidelines recommending PC for all patients with solid cancers
European Association for Neuro-Oncology (EANO)[8]	Y	Designated three main areas of PC for adult patients with glioma: symptom management, patient and caregiver needs, and PC (including but not limited to care in the end-of-life phase). Provides concrete clinical and management interventions for patients
National Institute of Health and Care Excellence (NICE)[9]	Y	Committee-level recommendations acknowledge that people with brain tumors have very specific needs that are often not met and provide general guidance on improving supportive and PC for adults with brain cancer
National Comprehensive Cancer Network (NCCN)[5,10-13]	Y	(1) Evidence-based recommendations addressing the integration of PC in oncology are available to both (a) clinicians and (b) patients
		(2) Specific recommendations for early PC in patients with CNS cancers
		(3) Patient-facing guidelines specifically for glioma
European Society for Medical Oncology (ESMO)[13,14]	N	Formal clinical practice guidelines for communication and support of patients and caregivers in chronic cancer care
European Association of Palliative Care (EAPC)[15]	N	Formal guidelines recommending PC for patients with cancer and noncancer diagnoses

Abbreviations: N, no; PC, palliative care; Y, yes.

concluded that "patients believe that palliative care would contribute to their emotional well-being" and that patients want health care clinicians to "aim to educate brain cancer patients about palliative care early and in a sensitive manner."[20]

Clinicians, patients, and caregivers should understand the concept of PPC versus SPC and their key differences (Table 2).[21] Briefly, PPC is provided by all clinicians, including a patient's primary oncologist. By contrast, SPC is provided by an interdisciplinary team with specific training to address complex patient and caregiver needs. SPC clinicians are experts in serious illness communication, which supports patients and caregivers navigating complex emotions and multidimensional distress that arise because of serious illness. PPC and SPC are intended to address needs beyond the typical therapeutic interactions that focus on imaging results and cancer-directed medications. For people with CNS cancer, PPC can and should be delivered by any of the specialists involved in their day-to-day care (Table 2). Although clinicians, patients, and caregivers may perceive advantages and disadvantages of PPC versus SPC implementation, SPC demand will continue to outweigh its availability as the global burden of cancer and other serious health-related suffering is estimated to double by 2060.[22]

LEVERAGING SERIOUS ILLNESS COMMUNICATION

Vignette 1. Continued

> Carol is exhausted and frightened. She knows the median survival for glioblastoma is approximately 12-15 months from diagnosis. Within this disease trajectory, David's clinicians know there is often a period of relative functional stability following initial treatment—a window clinically underutilized for the kinds of conversations that would be beneficial for Carol and David.

TABLE 2. Comparison of PPC and SPC

PPC	SPC
Performed by all clinicians. For example Medical oncologist Neuro-oncologist Radiation oncologist Surgeon Primary care physician Physiatrist Oncology nurse, nurse practitioner, physician assistant	Performed by an interdisciplinary team of palliative care specialists that includes any of the following: Board-certified palliative medicine physician Advanced practice provider Nurse Social worker Psychologist Chaplain Pharmacist
Standard skills and competencies expected of all clinicians, including Basic symptom management of pain, nausea, anxiety, and depression Basic goals of care conversations Establishing code status Advance care planning especially to establish health care surrogate Timely hospice referrals	Specialized palliative care addresses Complex (and/or uncontrolled) symptom management Evaluation and management of moderate to severe distress (social, emotional, spiritual, existential) Conflicts between or among patient/caregiver/family members/healthcare staff Needs for expert communication and goal setting Complex hospice transitions
Occurs in any health care setting (inpatient, outpatient, etc)	Occurs in any health care setting *where available*
Provided along with standard treatments	Provided along with standard treatments

Abbreviations: PPC, primary palliative care; SPC, specialty palliative care.

The Conversations

Carol says: "*He won't talk about it. He acts like everything is fine. And I'm the one holding all of this on my own.*" She wants to know how long he has and what the time they have left will look like. She wants to plan—for the children, for finances, and for herself.

David, when contacted separately through the clinical team, is initially resistant. He eventually says: "*I know what's coming. I just don't want to spend whatever time I have talking about it.*"

This is not denial in the clinical sense. This is an individual making an active, values-based choice about how to live with a life-limiting disease—what Cicley Saunders would have recognized as part of the existential, social, and psychological dimensions of total pain: the suffering that arises not from physical symptoms alone, but from loss of meaning, role, and future.[6,23] David is a person who has lost control of almost everything, and this is one of the few things he can still control.

COMMUNICATION FRAMEWORK: THE SERIOUS ILLNESS CONVERSATION GUIDE

The Serious Illness Conversation Guide (SICG), developed by Ariadne Labs, provides a structured but flexible approach to exploring what matters most to patients facing life-limiting illness.[24] It moves through four domains, using questions designed to open rather than foreclose:

- illness understanding,
- information preferences,
- goals and fears, and
- what gives life meaning.

Rather than leading with prognosis, clinicians ask first: "*How much do you understand about where you are with your illness?*" and "*How much information would be helpful for you?*"

This framing is particularly valuable in person-centered conversations about navigating life with glioblastoma, where patients and caregivers often differ substantially in their information needs and coping styles.[25] In David and Carol's case, using SICG-structured conversations (held separately from each other) allows the clinical team to meet each person where they are, rather than defaulting to the most information-hungry partner setting the agenda for both.

In the clinical consultation, the SPIKES protocol offers a practical structure: establishing the Setting, exploring Perception, obtaining Invitation to share information, providing Knowledge, responding to Emotion, and Summarizing with a strategy (Table 3).[26] Responding to emotion is often the step most abbreviated or omitted, yet it is where trust is built or lost; it is where deep emotional processing is done.[27] When Carol says "*I just need to know what I'm preparing for*," the response that helps her is not immediately informational; it is the one that names and validates her experience before anything else is offered.

COMMUNICATION USING A COACHING MINDSET AND RESPONDING TO EMOTION HELPS

With Carol, serious illness conversation does not start with information; it starts with exploring what she actually needs that underpins her information-seeking. The GROW model—Goal, Reality, Options, Will (Table 3)—provides a useful structure here, and in practice, it is important to identify the goal before moving onto the reality: *what is happening for Carol right now*, in her own words.[28] Through careful questioning, she realizes that what she needs most is not a timeline but to address her social suffering by feeling less alone in carrying the knowledge she already has. She needs practical help—with financial planning, with having age-appropriate conversations with her children, and with building her own support network so that David is not her only source of connection.

The NURSE framework—Naming, Understanding, Respecting, Supporting, Exploring—for responding to emotions (Table 3) is a learnable communication skill that

TABLE 3. Frameworks for Coaching and Communication

Framework	Acronym	Elements and Examples
SPIKES protocol for delivering news	Setting Perception Invitation Knowledge Emotions Strategy and summary	Ensure private space without interruptions Elicit knowledge of the current situation Obtain permission to give news Provide information in short statements, checking for comprehension Respond empathically to emotions Review main points, strategize next steps, and summarize the plan
GROW model for problem-solving and decision making	Goal Reality Options Will	What do you want? What is happening now? How do you feel? What are your options? What could you do? What will you do? How will you do it?
NURSE statements for empathically responding to emotion	Naming Understanding Respecting Supporting Exploring	It sounds like you might be feeling overwhelmed Hearing this helps me better understand I can see how much this means to you I will be here for you no matter what happens Could you say more what you are concerned about?

clinicians can use to compassionately express their understanding which facilitates emotional processing.[29] When a clinician says: "*It sounds like you're carrying an enormous amount and doing it largely invisibly*" (Naming and Understanding), Carol's response is to exhale and say: "*Yes. Exactly that.*" Something shifts. The subsequent conversation about what support might look like becomes possible in a way it was not before.

With David, the serious illness conversation centers on what matters to him right now. The Ask-Tell-Ask approach—asking what he already knows, offering information only in response to what he actually wants, and checking what he has taken from the exchange—allows him to remain in control of what enters the conversation (Table 4).[30] He is helped to articulate what a good day is for him, aiming to help him have as many as possible. He says: "*I want to go to the rugby. I want decent coffee. I don't want everyone looking at me like I'm already gone.*" This is, within the emotional intelligence–focused realm of serious illness communication, an expression of his values and his goals, along with acknowledgment of his poor prognosis and mortality. He conveyed information that is clinically and humanly vital, but that would likely never have emerged from a prognosis-led conversation.

Using serious illness communication frameworks allows Carol to get what she needs through a private conversation with the palliative care team, whereas David gets to set the terms of his remaining time. Their relationship, under extraordinary pressure, is given room to breathe.

THE CLINICAL LESSON

Because of cognitive dysfunction in those living with glioblastoma, the caregiver frequently becomes the primary interlocutor with the clinical team. Caregiver information needs and the patient's coping style can be in direct tension, a dynamic well-documented in the literature.[31,32] Integrating palliative care within a few weeks to months of the diagnosis creates the conditions in which these conversations can happen without crisis forcing them, or they may not happen at all. The principle applies with equal relevance in neuro-oncology: by using serious illness communication frameworks, individual and collective wants, needs, values, and priorities are elicited so patients, caregivers, and their clinicians can navigate next steps in the patient's care.

TABLE 4. Key Communication Skills

Skill	Example
"Tell me more"	"Tell me more about what is most important to you."
Ask-Tell-Ask	"What do you want to know about….?"
	"The information I hear you are seeking is…"
	"Does this information help you?"
"I wish…."	"I wish more chemotherapy would change what is happening right now."
"I worry…"	"I worry that more chemotherapy will cause you feel sicker from more side effects without changing the cancer's growth."
Silence	Holding space for strong emotion with compassion by remaining silent and holding the person expressing emotion with unconditional positive regard

Low-Grade Glioma—The Uncertain Wait

> **Vignette 2:** Priya is a 34-year-old teacher, diagnosed with a WHO grade 2 IDH-mutant astrocytoma 18 months ago after presenting with new onset headaches with what Priya described as "odd sensations". She underwent resection and is currently on active surveillance with regular MRIs. She is back at work. To colleagues and her students, she looks well. To herself, she is waiting. She is articulate and organized, having created a list of questions and a spreadsheet of symptoms she has been tracking. She has read grade 2 IDH-mutant gliomas carry a median survival that has improved significantly with modern molecular testing and targeted therapy, with many now living 10 years or longer, though the disease eventually transforms to higher grade in most cases. This is not, as it is sometimes characterized by clinicians to patients, a reassuring prognosis to Priya. Rather it is a different kind of prognosis--one that requires a different kind of support over a far longer timeframe.

THE CONVERSATIONS

Priya's challenges though different from someone living with glioblastoma are no less profound. She describes living in a state of *suspended animation*—too well to claim the identity of someone who is seriously ill and too ill to reclaim the future she had planned. She had expected to be promoted. She had expected to start a family. Now, every decision feels contingent on something she cannot name.

She is also managing the exhaustion of other people's relief. "*Everyone keeps saying how well I'm doing. And I am. But I also have a brain tumor, and nobody seems to want to acknowledge both of those things at once.*"

Her partner, Sanjay, is loving but avoidant. He does not want to talk about the tumor. He says that talking about it makes it more real. Priya finds this isolating.

This pattern—the person living with the tumor diagnosis carrying existential awareness that those around her cannot tolerate—is well-recognized in the qualitative medical literature. Cavers and colleagues describe the social and existential isolation experienced by people with glioma as distinct from other cancer diagnoses, partly because cognitive and personality changes, when they occur, can alter the very relational capacity on which support depends.[31] Even in the absence of overt symptoms, the anticipatory grief and identity disruption are present from diagnosis.

COMMUNICATION FRAMEWORK: EXPLORING INFORMATION PREFERENCES AND FUTURES

For Priya, the clinical challenge is not acute. She is not in a medical crisis. But the absence of medical crisis should not be misread as the absence of need. The SICG question "*What are your biggest fears or worries about the future?*"—asked not in a moment of deterioration but in a routine surveillance consultation—opens a conversation that transforms her engagement with her own care.[24] She says that her biggest fear is not death, but cognitive change: losing her ability to teach, to think quickly, and to be herself in a classroom. This is information her clinical team did not have, and it changes the conversation about when to initiate treatment.

The Ask-Tell-Ask approach is again valuable here.[30] Rather than offering information about transformation rates and treatment timelines (Tell), the clinician first asks: "*What would be most helpful to understand about what the next few years might look like?*" (Ask). Priya says that she wants to understand what signs to watch for and what control she has over timing. The information that follows is calibrated to that question, not to a generic prognostic summary (Tell). Checking what she has understood and what she wants to do with it (Ask) closes the loop and returns agency to her.

WHERE PALLIATIVE CARE'S EXTRA LAYER OF SUPPORT HELPS

For Priya, the palliative care clinician relationship provides the one space where she does not have to manage other people's feelings. This matters. The emotional labor of protecting others from distress, a burden disproportionately carried by patients with nonvisible illness, is itself exhausting and isolating.[33]

Using the GROW framework, the conversations begin with an honest exploration of reality: not the medical reality, which Priya understands well, but her lived reality and the decisions she has frozen, the relationships she is navigating with insufficient support, and the sense of purposelessness that has crept into her working days.[28] The goal that sits behind this is not dramatic: she wants to feel like she is living her life again, not waiting to see what happens to it.

By contemplating her options framed in the GROW model, Priya conceptualizes ideas and thoughts she had not allowed herself to consider. She had stopped applying for promotion because it seemed pointless. She had stopped discussing children with Sanjay because the conversation felt impossible. Priya's catalyst was the opportunity to separate the practical questions (which are answerable, with the right information and support), from the existential ones, which require a different kind of holding. She approaches her fertility specialist. She applies for the promotion and gets it.

The SICG framework again proves to be useful, this time in helping Priya to have a different conversation with Sanjay.[24] Rather than approaching him with information, which he is known to avoid, she approaches him with a named need of what is most important to her: "*I don't need you to know what's going to happen. I just need to not be alone with it.*" The palliative care clinician helps her find this formulation. It is, in the language of serious illness communication, an expression not of prognosis but of relational need and navigating social distress. This expression of Priya's need is one Sanjay can respond to.

Priya also prepares differently for her next magnetic resonance imaging (MRI) review. Rather than arriving with a spreadsheet, she arrives with two questions that matter to her. The consultation shifts from data-gathering to dialogue about her disease status to a meaningful conversation. She leaves feeling that she has been seen and heard in addition to informed about her stable surveillance MRI.

THE CLINICAL LESSON

Low-grade glioma presents a distinct and often under-recognized challenge: the patient is well enough to be largely invisible to supportive care services but is living with a chronic existential threat that permeates every major life decision across a horizon of many years. Systematic reviews of supportive care needs in patients with brain tumor consistently identify unmet psychological and social needs even in patients who appear to be functioning well.[33-35] Palliative care, in this context, is defined by the WHO as the active total care of patients whose disease is not responsive to curative treatment and is applicable from the point of diagnosis.[36] The palliative care approach of being person-centered on their illness experience and what is most important is particularly well-suited to the long trajectory of low-grade glioma. It meets patients where they are, over time, without requiring them to be in crisis to access support. For clinicians, this vignette illustrates that the absence of acute distress is not evidence of absent need and that the most important conversations are often the ones that happen before anything has gone wrong.

CONCLUSION

For people with CNS cancer, their disease may affect every aspect of their physical, cognitive, and emotional well-being—the core of who they are as a human being. They face a highly uncertain future and need as much support as possible, as do their caregivers and family members. David's case depicts what happens when the patient and the caregiver have profoundly different needs and coping styles. Serious illness communication did not resolve that tension by forcing engagement with prognosis. It resolved it by meeting each person where they were in their emotional processing of the cognitive information about the cancer. Priya's case makes the harder argument: that a patient who is functioning well by every clinical measure can simultaneously be living with a chronic existential threat that is quietly foreclosing her future. The absence of acute distress is not evidence of absent need. The featured vignettes highlight how people like David and Priya present with different diagnoses, different disease trajectories, and different palliative care needs, yet both illustrate the same core proposition: that people with CNS cancer need and deserve care focused on their illness experience and optimizing how they are feeling and functioning concurrently with their cancer-directed care. Together, these cases make the case for communication that is built into care from diagnosis, not grafted on when clinical deterioration emerges. The frameworks described here—SICG, SPIKES, NURSE, Ask-Tell-Ask, and GROW—are teachable, learnable, and adaptable communication skills. The use of these serious illness communication frameworks actualizes the translation of cancer science into high-quality person-centered cancer care. The science of neuro-oncology has made extraordinary advances. Translating those advances into health care that is truly person-centered requires clinicians to bring the same rigor and intentionality to communication that they bring to cancer treatment.

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