Summary

Based on their experience as teachers of communication skills training for oncology clinicians, the authors report their observations and reflect on open questions and future challenges with regard to communication in cancer care.

Both of us have been training oncologists and oncology nurses in communication skills training (CST) for many years (Kiss 1999). This might be the reason why the editor asked us to comment on CST from a clinical point of view. We will therefore share some observations we made while doing such training and we will try to define future tasks.

12.1 The Gap Between Research and Practice

At first glance, CST in oncology seems to be a success story. The effectiveness of such training has been demonstrated by a randomised trial with UK oncologists (Fallowfield et al. 2002). Research in patient–professional communication in cancer is growing, as illustrated by the fact that a special issue of the journal Psycho-Oncology has been devoted to this subject (Hack 2005) and that the results of communication skills training are published in mainstream cancer journals (Delvaux et al. 2005). CST that focuses on specific topics such as shared decision-making, detecting psychosocial distress in cancer patients and information about randomised clinical trials has been developed and evaluated recently (Jenkins et al. 2005). Finally, communication skills training has become mandatory in some curricula in oncology and haematology.

However, some open questions remain concerning how to translate the results of this research into clinical practice:

1. Who will pay for the CST if it becomes part of the training of oncologists and oncology nurses? Effective training has to be conducted in small groups, with an experienced trainer, which is costly. Resources for continuing medical education (CME) are limited, and sponsorships from pharmaceutical companies have become difficult. Our experience in Switzerland, Austria and Germany is that physicians are able to pay themselves, but nurses can hardly afford it. In recent years, the support of hospitals for working leaves and funding has diminished.

2. To the best of our knowledge almost all randomised trials of CST in oncology were conducted with participants who volunteered. For example, in the study of Merckxart and co-workers (2005), the final sample of 72 participants was based on 214 invitations to participate made by telephone, 163 individuals were informed personally and 173 in groups. This means that the participants were probably highly motivated and not representative. If the aim of CST is not only to "preach to the converted" but also to include a larger group, we do not know if the effect of the training will be the same. Our experience in Switzerland, where CST is mandatory for oncologists, is that most physicians appreciate the train-
ing, but some do not and the improvement of their communication skills may therefore be moderate.

3. Until now, most training has been provided by very motivated and enthusiastic trainers who have worked in this field for years. If CST is to spread, more trainers will be needed. To form these trainers, “train the trainer courses” will be necessary. Whether or not these new trainers will be as effective as the current ones is unknown.

4. Outcome measurements such as analysis of the communication of professionals interacting with simulated or real patients before and after training is costly and time consuming, and experienced raters are needed. How can quality of future training be assessed while funding is restricted? It is unclear what kind of measurement is appropriate to evaluate such training. Maybe rating tools that assess communication competence could serve to measure outcomes in a less costly way (Schirmer et al. 2005).

12.2 Why Is CST a Major Theme Only in Oncology?

It is hard to find any scientific literature on CST in other specialities, e.g. gastroenterology or cardiology. In gastroenterology the most frequent patients are those with functional disorders such as irritable bowel syndrome. Until now, no trial has been effectuated to demonstrate that a CST enhances communication competence of gastroenterologists (Drossman 2005). To give another example: Severe chronic heart failure has a worse prognosis than many malignancies. However, we are not aware of any CST of cardiologists, who often have to give bad news to patients and inform them about their prognosis.

One major reason may be that oncology is still linked with the image of incurable and suffering patients, despite the fact that nowadays about half of all cancer patients can be cured. There seems to be a change in current attitude: The Institute of Medicine in its 2004 report, “Improving Medical Education: Enhancing the Behavioral and Social Science Content of Medical School Curricula” identifies communication skills as one of six curricular domains (Institute of Medicine 2004). CST in oncology is a first step; other specialities will follow.

12.3 Do We Contribute to the Strain of Healthcare Providers in Palliative Care?

Poor communication with patients and their relatives may be a consequence of unresolved distress of healthcare providers, but it may also constitute a source of major distress in physicians and nurses providing palliative care (Simpson et al. 1991). However, adequate communication with the severely ill and the dying patient and his loved ones may also cause distress and—if coping mechanisms fail—burnout. The desire to be a good caregiver who not only provides efficient, good medical treatment but also does her best to adequately communicate and to emotionally support the patient and his family may overburden the clinician. Palliative care is characterised by close and caring relationships and emotionally intensive work on the one hand, and anxiety and anger arising from the repeated confrontation with death and dying, on the other. This requires adequate coping strategies and balanced relationship between proximity and distance with the patient (Kash and Holland 1990). Distancing oneself from patients and their suffering and concentrating on medically routine tasks are self-protective behaviours. If confronted with multiple stressors while lacking adequate coping strategies like seeking self-esteem in interests other than caring for patients (work–life balance) or mobilising support from colleagues and friends, distancing oneself from patients may last and become a symptom of burnout (Lown 1996; Lopez-Castillo et al. 1999; Maslach et al. 2001).

The demands of better understanding and meeting the psychosocial needs of the severely ill may further increase feelings of insufficiency and failure in healthcare providers who fail to adequately distance themselves from the suffering of their patients. As a consequence, those who provide CST—especially if it is mandatory—should always take into account the trainees’ re-
sillence and their skills at coping with repeated bereavements. In our opinion, training should include small-group discussions of the trainees’ work-related emotional distress and their coping strategies. Rigid and straining demands on oneself often arise from an unconscious wish to “heal” severely ill patients rather than to accompany and care for them in their last period of life. Such motivations should be addressed and analysed. Trainees should not be confronted with new demands like better communication behaviour with patients and their loved ones without reducing such overtaxing demands to the self. Our experience in guiding CST led us to combine such training with a limited and work-related process of self-reflection and self-experience (Balint 1964). We learned by experience that participation in theme-centred small-group discussions or Balint groups opens a space of reflection and allows participants to decrease unrealistic self-demands and to improve self-protective behaviours. Often this is a prerequisite for an effective CST.

12.4 Why Is the Focus Only on the Patient, While Communication Within the Healthcare System Is Often Neglected?

Severely and chronically ill patients often complain about poor communication between medical specialists and between physicians and nurses in the hospital, as well as poor communication between specialists and family physicians. Poor communication leads to unclear and often conflicting information on patients and their relatives, and subsequent uncertainty, ambivalence and sometimes difficulty in complying with treatment. Quality management and organizational development activities can address horizontal (inside the hospital) or vertical (between hospital and ambulatory care) communication problems within the healthcare system, can analyse the reasons for them and develop solutions (Schaufeli and Enzmann 1998).

Better communication within the hospital is impeded by recent developments such as the reducing length of stay in hospitals without adjusting the offer of ambulatory care, staff shortening in oncological or palliative care units, cutting reimbursement and “outsourcing” of psycho-social services. These factors prevent trainees who successfully take part in a communication skills course from putting their new knowledge and skills into clinical practice. Such frustrating experiences may lead to resignation and a relapse to “old” communication patterns. CST on an individual level should be accompanied by efforts on a systemic level to develop adequate conditions for better communication. This includes quality management activities as well as political commitment.

12.5 What Does It Take to Become a Good Trainer for CST in Oncology?

CST will spread, since communication has been recognised as a key element of cancer care; therefore, it is worth identifying the qualifications of a good trainer.

12.5.1 Personality

Trainers should be comfortable and enjoy communication with other people. They should have a talent for dealing with unexpected situations and the ability to focus more on persons’ resources than on their shortcomings. Trainers should be reflective and open-minded about processes of work-related self-experience. To decrease the risks of the development of pressure towards perfectionism and of developing burnout in the trainees, trainers should acknowledge their own limits and abstain from promoting narcissistic feelings in the trainees (“becoming a perfect physician/nurse”).

12.5.2 Professional Background

Most trainers are either healthcare professionals or clinical psychologists. Both backgrounds have their advantages and disadvantages: Healthcare
professionals are more familiar with the medical environment but tend to underestimate that changing human behaviour, i.e. communicating in a different way, is a very complex and challenging task. Clinical psychologists on the other hand tend to underestimate the specifics of medicine because they are not familiar with this work. In our experience, working in a psychiatric or psychosomatic consultation-liaison service in a palliative care or oncology unit and therefore being familiar with the demands and problems of this kind of work is a good prerequisite for becoming a trainer (Breitbart and Lintz 2002; Söllner et al. 2004). Regardless of the professional background, trainers should be familiar with group dynamics. They should be able to provide a protective and supportive environment in the group that allows each trainee to openly address his problems of communication with severely ill and dying patients.

12.5.3 Framework

In order to teach communication skills, a multidimensional framework is needed. A learner-centred approach is essential: The essential characteristics are provision of a cognitive component or evidence base for suggested skills, a behavioural component allowing participants to rehearse the actual communication skills required through role play with patient actors playing patients, and an affective component permitting participants to explore the feelings that communicating about difficult issues evoke (Fallowfield and Jenkins 2004).

12.5.4 Supervision

The first step should be that future trainers participate themselves in a CST as a trainee. Then, specific parts of the training should be done by future trainers under supervision of experienced trainers. The easiest part involves the lectures; the most difficult involves the interactions such as role-playing, giving feedback and dealing with group dynamics. As it is currently demanded from trainee doctors and nurses that they videotape interaction with simulated or real patients, it should be the same for future trainers to videotape themselves when they interact with participants of CST.

Communication in cancer care has been recognised as an important task in the daily clinical oncology practice, and the first steps towards improving the communication skills of oncology clinicians have been undertaken. A wider implementation of CST in oncology faces various challenges and obstacles. As with any other medical activity, progress in communication will require a comprehensive reflection of the topic, courageous and skillful trainers who are able to "spread the message" and a rigorous scientific investigation to accompany these efforts.

References


