The Swiss Communication Skills Training (CST) for oncology clinicians was initiated in 1998 by the Swiss Cancer League (SCL), who mandated a national task force\(^1\) to elaborate a concept for a CST for oncology physicians and nurses. In order to learn about key elements of existing CST, the task force, together with the SCL, organized a meeting with three invited experts—Leslie Fallowfield and Peter Maguire from the United Kingdom, and Darius Razavi from Belgium—who presented their models by means of interactive workshops; chiefs of service and head nurses from different oncology centres participated in this meeting. Based on these experiences, the task force developed a concept for a national CST for oncology clinicians.

Initially, a train the trainers' course was organized for the members of the task force allowing them to experience the CST as participants and to gain insight into its dynamics. Following a pilot CST, organized in the German, French, and Italian parts of Switzerland for local chiefs of oncology services and head nurses, the Swiss CST was implemented; it was officially endorsed by the Swiss Society of Medical Oncology (SSMO), and sponsored by two pharmaceutical companies who were willing to financially support this training during the first years.

In 2001, the SSMO declared this CST to be mandatory for physicians specializing in oncology. By the end of 2007, about four hundred physicians and nurses working with cancer patients had participated in this training.

**Setting of the Swiss CST**

Several times a year, a CST for up to ten participants is organized by two of the trainers. The trainers have extensive experience in psycho-oncology; their professional background is psychiatry, psychology, internal medicine, and nursing, and all of them have been trained in psychoanalytic, systemic, or cognitive-behavioural psychotherapy or in psychosomatic medicine and supervision. The CST starts with a 2-day course, followed by four to six individual supervisions and ends with a half-day course 6 months later. The training is based on case discussions, role-plays, and video-analyses of participants' interviews with a patient simulated by an actor (each participant is filmed at the beginning and the end of the training). The Swiss CST provides only a very limited amount of theory; it is mainly based on interactivity and practical exercises by means of case presentations, role-plays, analyses of video sequences, and guided imagery.

\(^1\) The initial task force consisted of: M Andrey, J Bernhard, A Bischoff, L Dietrich, Ch Hürny, A Kesselring, A Kiss, F Stiefel, M Tomamichel and B Wössmer.
Objectives of the Swiss CST

The training focuses on four elements of communication: (1) structure, (2) exchange of information, (3) emotions and (4) relational aspects. While these elements are interdependent and occur simultaneously, for didactic reasons they will be discussed separately and illustrated by examples.

Structure

The training aims to raise participants' awareness of structural elements of the consultation, such as the setting (time, space, participants, etc.), negotiation of the patient's and clinician's agenda, announcement of transitions to new topics during the interview and regular intermediate syntheses of what has been discussed. The example in Box 55.1, taken from a CST, illustrates the difficulty of a nurse to follow a coherent structure, changing topics rapidly and without announcing the transitions.

Exchange of information

Participants of the training learn that different types of questions (closed, open and leading questions) have different functions within a consultation. They also learn that non-verbal expression of time pressure can hamper exchange of information, while a concentrated interest in the patient can facilitate the exchange of information. Training also focuses on using language that can be understood by the patient, limiting the amount of information provided; checking patient comprehension; and identifying anxiety or other sources of a diminished capacity, which may affect patient retention of information. Box 55.2 illustrates an exchange of information characterized by medical jargon, which may not be understood by the patient.

Emotions

The CST teaches how emotions of the patient can be perceived (verbal and non-verbal expression) and how they can be contained in an empathic manner. Participants learn to distinguish between a cognitive expression (communicating information) and an emotional expression (communicating a feeling), and learn how to respond accordingly. Box 55.3 illustrates the failure of a clinician to recognize this distinction and then responds with a cognitive, medical answer, instead of providing empathic support.

Box 55.1 Structure—chaotic and transitions not announced

Nurse: Before you receive chemotherapy, we will give you a medication to help with the nausea.
Patient: ...good.
Nurse: Chemotherapy is not always associated with nausea, but we would like to prevent it, that's why we prescribe you this medication. ... Where do you work?
Patient: I own a small factory...
Nurse: The chemotherapy should be well tolerated; we only give you this medication as a precaution.
Patient: OK.
Box 55.2 Exchange of information—jargon, lack of checking

Physician: You describe what sounds like a paraneoplastic phenomenon.
Patient: Can't we do something, where does it come from?
Physician: Paraneoplastic syndromes have different origins. It is difficult to treat.
Patient: But I thought that I have only cancer...
Physician: Paraneoplastic symptoms may be related to immunological responses induced by your cancer.
Patient: Immunological responses?
Physician: Yes, immunological responses, leading to paraneoplastic syndromes induced by cancer, very rare...

Relational aspects

Relational aspects of the interview are important, but difficult for participants to perceive. Relational aspects are discussed by viewing and analysing selected video sequences and role-plays. Sequences characterized by abrupt transitions from one topic to another; an escalation of an underlying relational dynamic; inadequate non-verbal expressions or stagnation in a topic, are used to illustrate relational aspects of communication. Participants recognize that effective communication is not concerned with the question 'who is right?' and are trained to let the patients express their views and to accept that different views can coexist. Box 55.4 illustrates how the anxiety of a clinician, projected on to the patient, leads to the proposition of a consultant instead of first clarifying the patient's needs.

Box 55.3 Emotions (deception)—failure to let the patient develop his perspective and failure to provide empathic support

Physician: To summarize, the results show that the cancer has come back.
Patient: But I thought that I was cured!
Physician: I told you two years ago...
Patient: That doesn't make sense, I don't want any further treatment.
Physician: I would suggest a new chemotherapy...
Patient: With the same results?
Physician: Chemotherapy may reduce the tumour mass and prolong your life.
Patient: I don't know; this is so unexpected.
Physician: Palliative chemotherapy could have a positive impact.
Box 55.4 Relational aspects—projection of anxiety and introduction of a consultant without clarifying concerns

Patient: I do understand. The operation was only partly successful and now chemotherapy seems necessary.
Physician: That's correct.
Patient: (sighs) My kids are still small and...
Physician: We do have psycho-oncologists, they could be of help.
Patient: I would like first to think about everything.
Physician: I just thought that maybe you feel lonely and the kids...
Patient: No, my husband is very supportive.

While improvements with the first three elements (structure, exchange of information and containing emotions) can be obtained within the first two days of the training, relational aspects are more easily discussed in individual supervision.

Observations from the Swiss CST

Communication difficulties in the video-taped interviews are identified by an unbalanced focus on medical issues, a predominance of closed questions, abrupt transitions from one topic to another, interruptions of the patient, premature or inadequate comforting or avoidance of patients' concerns. For each participant, different sequences of their filmed interviews are selected and discussed.

With regard to the different elements of the interview, we observe the following difficulties during the training. Interviews are 'under-structured' (e.g. when talking to anxious patients) or 'over-structured', with the consequence that the patient is deprived of the possibility to exist as an individual. Information is not adapted to the patient's needs; clinicians show difficulties distinguishing between cognitive and emotional expressions of the patient; questions are answered without clarifying underlying concerns; and the comprehension of the provided information is not checked. Emotions of the patient are not identified or are avoided, and helplessness exists as to how to respond to an irritated, anxious or sad patient. Inadequate relational reactions from clinicians are linked to specific situations, such as the limits of medical treatment, transition between curative and palliative treatment or the patient's refusal to comply with prescriptions; in such moments, clinicians are subjected to pressure and may lose the capacity to continue to support the patient and respond with empathy.

Specificities of the Swiss model: interdisciplinary training, individual supervision and mandatory training

Interdisciplinary training is a key element of the Swiss CST. Working with both nurses and physicians allows the opportunity to, not only to practise interdisciplinary communication, which is often a major problem in daily clinical care, but also the opportunity to recognize the specific challenges and responsibilities of each profession through the case discussions and video-taped interviews.
We have observed differences between professions with regard to communication skills. In general, physicians have a good capacity to structure the interview, to adequately provide medical information and to assume leadership during the consultation. On the other hand, physicians sometimes structure the interview in a way that hinders the discussion of certain topics, such as prognosis of the disease; they forget to check if the information has been understood by the patient; and have difficulties perceiving the emotional climate, and may react with irritation when confronted with 'difficult' patients. Nurses usually show a good capacity to obtain sensitive information, to facilitate emotional expression and to contain patients who are angry, anxious or depressed. On the other hand, they sometimes lose leadership during the interview, have difficulties changing back to the medical agenda or to end a consultation, and are inclined to take the blame when the patient is irritated by the disease, its treatments or the physicians.

However, working with participants of different professional backgrounds also has disadvantages. If, for example, a professional group is over-represented, specific topics of the minority may be neglected and some participants may feel inhibited to discuss sensitive issues in front of the other profession.

After the initial 2-day training, participants attended four to six individual supervisions over the next 6 months. In the French part of Switzerland, supervision is provided either in the trainer's office or, more rarely, in the oncologist's office. In other parts of Switzerland, supervision is conducted over the phone due to geographical distances. Participants wish to discuss very different issues in the supervision; some like to work on audio- or video-taped consultations, others demand to reflect on difficult cases or ask for 'live supervision', with the supervisor being present in the medical consultation.

Often participants present a 'difficult patient' and then, through supervision, recognize that the problem they encounter is related to their own communicational difficulties. For example, a young oncologist who worked in a palliative care unit presented the case of a 55-year-old man with brain metastases who asked for another MRI. After the oncologist replied that 'this was not necessary any more', the patient refused to speak to him for three days. During supervision, the oncologist recognized that instead of clarifying the underlying concerns of the patient's question, he had responded with a 'medically correct', but empathically inadequate, answer.

Sometimes supervision may also lead to a reflection on a participant's personal issues that are affecting communication. For example, an oncologist presented the case of an elderly patient suffering from advanced breast cancer, who complained about pain but at the same time refused analgesic treatment; the oncologist became so angry that he started shouting at her. During supervision, the clinician first realized that his 'unreasonable behaviour' of the patient may have had a hidden meaning (preservation of autonomy, fears associated with pain medication, etc.). Once the clinician realized these possible sources of the patient's behaviour, he was able to reflect on his own strong emotional reaction. He reported that he not only felt angry, but also very anxious when he shouted at the patient, and linked his reaction to his own medical history of melanoma three years ago: 'I would certainly not be alive any more if I had not followed the doctor's advice and someone not following medical advice had certainly provoked this great deal of anxiety'. During follow-up supervisions he became more and more aware of how his own medical history affected his psychological state and interfered, as in the case he presented, with his clinical work. The presented case was finally understood as a collusion (a reaction of the clinician, which is shaped by an unconscious and unresolved problem he shares with the patient); both were struggling with dependency/independency issues, manifested in the patient by the refusal to accept pain medication and in the physician by the refusal to integrate that he had recently been himself a patient. These insights and the experience of the supervision with a mental health professional motivated this oncologist to enter psychotherapy.
The 'narcissistic deconstruction' that participants experience when confronted with their filmed interview in CST often leads to a crisis situation, which stimulates a reflection on (professional) identity. In individual supervision, participants start to discuss sensitive issues and some of them link their own (biographical) elements with difficulties in daily clinical work. Individual supervision is, therefore, a cornerstone for the identification and analysis of relational aspects of communication and allows one to recognize that communication is a co-construction, which demands not only technical skills, but also the willingness to reflect on oneself and one's own relational patterns. The confronting experience in CST is certainly a key element for change and improvement of skills; for some participants, however, it represents too much of a challenge to face. We have observed on rare occasions that participants experienced great difficulties in the training and were left quite distressed. While most of the vulnerable participants seem to benefit from training, for a minority, the experience can be counterproductive. However, up to now we lack a procedure to exclude these clinicians from CST and to offer them an adequate alternative.

Until the decision of the SSMO to declare CST as mandatory for specialization in oncology, participation was voluntary. Since then, some of the clinicians enter the training with ambivalent feelings and sometimes explicitly declare that they are only motivated by the fact that CST has become mandatory. However, even these ambivalent participants generally engage actively in the CST and we observe that defensive oncologists quite often turn from passive resistance to motivated participation, and then benefit a great deal from training. The fact that the CST is mandatory, therefore, allows otherwise refractory physicians to gain a more constructive perspective with regards to communication in cancer care. It also provides a powerful signal of the SSMO to the medical community, to the patients and to society as a whole, that communication matters for oncology clinicians. We are, therefore, very grateful to the SSMO for their support and the trust by declaring this CST as mandatory for oncology physicians.

**Research**

The evaluation of the CST by the participants (2), effectuated by the SCL, was very positive with regard to the perception of different skills improvements, the various contents of the model and the trainers, confirming the impression of the task force that the training is appreciated.

The Swiss CST in oncology has been investigated by means of three scientific projects, all financially supported by Oncosuisse (www.oncosuisse.ch). The first project (1) evaluated the videos before and after CST, and focused on clinician-patient interactions. The videos of the 258 nurses and physicians who participated in the Swiss CST were analysed with the Roter Interaction Analyses System (RIAS), which yields categories under which patient and professional utterances can be summarized. Furthermore, it reports on the emotional climate of the interview, using global ratings. Interviews were also analysed with the Observing Patient Involvement Scale (OPTION), which assesses to what extent professionals involve patients in decision-making. A total of 54,692 utterances were analysed; the largest part of the interviews consisted of the exchange of information (36,677 utterances). The following results were observed: nurses showed a significant increase in the proportion of empathic statements (1.6% versus 3.2%) and of reassuring statements (2.3% versus 3.4%), a decrease in medical information given (17.8% to 13.3%) and an increase in closed and open questions concerning psychosocial information (2.8% to 4.0%); (simulated) patients speaking with the nurses showed a decrease of medical information provided and an increase of reported life-style information (8.1% versus 6.7%; 3.3% versus 5.7%). In physicians, an increase in checking/summarizing utterances (1.8% versus 2.3%) and an increase in patients' explicit
agreement statements (3.6% versus 4.7%) were observed. In addition, after training, the length of patients’ speech without being interrupted by the nurses increased (3.7 to 4.3 utterances), but not when speaking with physicians (2.8 versus 2.9 utterances). The authors concluded that there were many significant improvements in nurses on various dependent variables, but for the physicians the outcome was more limited.

The second project focused on psychodynamic aspects of CST (4, 5). The aim was to investigate if clinicians’ defence mechanisms are modified by CST, based on the hypothesis that this is the underlying process of skills improvement. Operating without conscious effort and triggered by anxiety-provoking situations, defences contribute to the individual’s adaptation to, and protection from, stress (6). Usually described in patients (for example, as denial when facing threatening news), defences operate also in any individual and thus also in clinicians under distress. In patients, different types of defence mechanisms have been described (7) and classified depending on their degree of adaptation to, or distorting of, reality, ranging from ‘immature defences’, such as projection or denial, to ‘mature defences’, such as displacement or intellectualization (7, 8). While patients’ defence mechanisms have been studied extensively in psychotherapy research (9), they have never been investigated in clinicians, not even in psychiatrists or psychotherapists (4, 5). As in patients, clinicians’ defences diminish their ability to integrate all aspects of a given situation, and thus may hamper the working alliance with the patient and the recognition of patient’s needs. Especially when immature defences are triggered, a clinician might then be perceived by the patient as detached and less empathic. After CST, most clinicians felt more secure (or less anxious) when facing patients in interviews and, therefore, less defensive, they were better prepared to encounter the patient, to perceive their emotions, and to respond empathically. In a first step of this project, a sample of 114 videos (57 videos pre- and 57 videos post-CST) were compared to 112 videos of a control group (56 videos using the same actors and the same scenarios as in the CST group, 56 videos 6 months later, no training). The videos were evaluated with the Clinician Defence Mechanism Rating Scale (DMRS-C) (9), which identifies a total of 39 defence mechanisms assigned to seven hierarchical levels: mature, obsessive, other neurotic, narcissistic, disavowal, borderline and action defences. Each level includes three to eight individual defences, which can be weighted according to its level of maturity and summed up to an overall defensive functioning score (ODF). Results showed:

(1) a high number (mean = 16, SD = 6) and a high variety (all hierarchical levels were observed) of defences triggered by the 15-minutes interviews;
(2) no evolution difference (ODF) with regard to defences between groups, but
(3) an increase of mature defences after CST for clinicians with an initial higher level of defensive functioning.

A follow-up project (10) aims to evaluate if levels of defences correlate with CST outcome, as measured by traditional measurements of skills improvement, such as the RIAS.

The third, ongoing project (11) is a linguistic investigation of CST, which aims to analyse the aforementioned sample (communication skills group and control group) from a linguistic perspective. This project aims to identify various quantitative and qualitative linguistic indicators of change of communicational competences. Furthermore, the data will also be evaluated with regard to socio-linguistic links between language and social identities, such as age, gender and professional background (physicians, nurses).

Ultimately, such research might allow the conceptualization of a broader offer of CST, which integrate relational and linguistic aspects in the training and which eventually might correspond more adequately to the individual needs of participating clinicians (12).
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References