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Authors: Stiefel F, Bourquin C

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Review

Moving toward the next generation of communication training in oncology: the relevance of findings from qualitative research

Short title: Communication training in oncology

Friedrich Stiefel* and Céline Bourquin

Psychiatric Liaison Service, Lausanne University Hospital and Lausanne University, Lausanne, Switzerland

*Corresponding author: Prof. Friedrich Stiefel, Psychiatric Liaison Service, Lausanne University Hospital, Les Allières, Av. de Beaumont 23, 1011 Lausanne, Switzerland; Phone: +41(0)21 3141090; Email: frederic.stiefel@chuv.ch

Abstract

Objective: The critics and recommendations for communication training in oncology call for new ideas, which may contribute to designing the next generation of training. The aim of this work was to search the literature on communication in oncology for empirically grounded observations that might be useful for the development of training approaches.

Methods: The approach consists of identifying findings that might serve as cues for the design of the next generation of training. The literature search strategy allowed the inclusion of 68 articles.

Results: Findings of the articles showed that multiple factors shape clinical communication: the functions and effects of information provision, the relational and interactional aspects of communication, its patient- and context-related dimensions, and the inner and outer barriers hampering the patient encounter that clinicians are facing.

Conclusion: A way to reach all oncologists and to provide training centered on the singular needs of participants, is a shift in the focus of training from communication tasks or communication-related situations to the clinician.

Practice implications: Training should focus on the competencies and qualities to be developed by clinicians, such as being flexible, able to adapt to the singular patient, sensitive to interactional aspects of communication, which influence the clinical encounter.

Key words

Oncology; communication training; clinical communication; inductive research; qualitative methods; clinicians.

1. Introduction

In a medical environment characterized by an increasing quantity of information, complexity of information, recognition of patient autonomy, and number of medico-legal requirements, communication has become a key element of cancer care [1].

Based on the observation that the communication behavior of oncology clinicians is modified by training, communication skills training (CST) programs were developed and widely implemented [2]. Meanwhile, several aspects of CST have been criticized, such as the conception of communication as a skill, the focus on technical mastery, the neglect of generic, relational and contextual elements of clinician-patient communication, and the risk of standardization of communication behavior [3-5].

These critics and the most recent recommendations for communication training in oncology based on the third consensus meeting among European experts (2018) [6] call for new ideas, which may contribute to designing the next generation of training in clinical communication for oncology clinicians. The aim of this work was to search the literature on communication in cancer care for empirically grounded observations that might be useful for the future development of training approaches.

2. Methods

Since we were interested in ideas or findings generated by observation, rather than those based on rules or given premises, our search focused on the qualitative inductive research literature.

Our goal was neither to provide a review or (critical) synthesis of this literature nor to analyze or assess its quality, but to identify selected findings that might serve as cues for the design of the next generation of communication training in oncology. We consider this approach as “translational” because we have tried to build on evidence from qualitative, inductive research to elaborate on communication training.

Since searching for qualitative research has been demonstrated to be difficult [7,8], we took advantage of two recent articles that reviewed and synthesized the literature on clinical communication and CST in cancer care: (i) a critical review by Salmon and Young, which had the ambition to build a new paradigm based on research evidence on clinical communication [9] [reference set 1], and (ii) a synthesis of the literature conducted by our team, which aimed to identify core components of CST programs [10] [reference set 2]. We assumed that the references identified in these works constituted relevant and comprehensive data sources for published articles on clinical communication and communication training in the oncology setting.

Articles were excluded if they were not published between 2010-2016, were not related to clinical communication, were not based on an inductive approach, were outside the oncology field, were not focused on postgraduate education or oncology clinicians and patients, were not addressing adult oncology, were guidelines, (meta)syntheses, (systematic (critical)) reviews or perspective articles. Sixteen articles (out of a total of 132 references) from reference set 1 met our inclusion and exclusion criteria and were retrieved and included; with respect to reference set 2 (n=485; studies reporting on communication training) [8], 15 articles were retrieved and included. Relevant records were then supplemented by articles published during the year 2016 in journals with the most frequent publications identified in reference sets 1 and 2. This overall search strategy allowed the inclusion of 68 articles.

In a second selection procedure, both authors read the 68 articles and repeatedly discussed the findings from each article, which led to the decision to divide the material into three piles.

The first pile consisted of articles (*n*=25) whose findings did not have the potential to be relevant for communication training, for example, because the focus of the studies was clearly on cultural aspects of a specific problem (e.g., providers' critical role in ensuring the satisfaction of American Indian and Alaskan Native persons with cancer by responding to their specific needs, such as respect for integration of traditional healing modalities [11]) or because they reported specifically on communication support tools. Findings of the articles in the second pile (*n*=18) were considered relevant for communication training since they indicated possible topics of interest, such as communicating bad and uncertain news, sexual concerns, or goals of care, or they addressed specific populations, such as migrants, survivors or the patient's family. However, these topics, which are already covered in traditional CST programs, did not indicate new directions for training and were therefore excluded from further investigation. The third pile consisted of articles (*n*=25) that were considered to provide a range of new and relevant aspects of clinical communication, which could plausibly be translated into the next generation of communication training and were thus further analyzed. The present manuscript focuses on the findings of articles from this last pile.

3. Results

The following results address six major themes identified to be relevant for future communication training: *information provision, shared decision-making, relationship building, communication barriers, and clinical communication training*. These themes were coherently derived from the articles' subjects and not from analytic identification and categorization. They were illustrated by excerpts from study findings.

3.1. Information provision

Because health information exchange has become a key element in cancer care, it is not surprising that several studies addressed this issue. The studies revealed that information provision cannot be reduced to a cognitive exercise; information is provided in a clinical and institutional context, has diverse interactional functions, and is concurrently shaped by the clinicians' and the patients' needs.

This "information spectrum" is illustrated in a study by Mendick et al. [12] of how surgeons provided information and of how breast cancer patients experienced it. The authors considered that *"Factual biomedical information was only a small part of the information that surgeons gave in post-operative consultations"*; they considered that their findings contribute to *"reinforce evidence that managing hope is a priority for both patients and clinicians across cancer care"* and questioned the current advocacy for the importance of providing detailed information. In another study on how surgeons manage giving information to patients with breast cancer, Mendick et al. [13] observed that "*Surgeons* *necessarily selected and shaped information, and patients relied on them to do so, because information influenced patients' hope, confidence in the surgeon's expertise, and relationship with the surgeon"*. The complexity of the communicative task thus consisted of multiple functions that surgeons had to reconcile: *"Patients needed their surgeon to be simultaneously honest in not hiding information and hopeful in presenting it optimistically"* [13].

A key for understanding such observations has been provided by Salander and Sandström [14], who stated—based on a study of cases discussed in a Balint-inspired reflective forum for medical residents in oncology—that patients and clinicians are, foremost, human beings with preexisting difficulties and life experiences, facing dilemmas and strains. Therefore, they emphasized the importance in clinical communication of "*listening to the 'voice of medicine' without disrespecting the 'voice of the life world'"* when patients, relatives, and staff members interact. This means, in other words, to give room to what physicians feel to be relevant to the medical consultation as well as to how patients explain their symptoms as being related to or resulting from other elements of their life [15].

Whereas information exchange in the included qualitative studies of clinical communication in cancer care appears to be more than just providing information, shared decision-making is actually more than choosing between alternative options.

3.2. Shared decision-making

Shared decision-making (SDM) is a paradigmatic example of clinical communication in the modern oncology setting: recent developments in patients' rights and the increased number of therapeutic options require an adequate communication and information disclosure. However, the model of SDM is complex and provokes debate with regard to its scope and limits in the clinical context. SDM cannot be considered solely as a matter of making a choice based on available information and evidence but implies the patient experience, and relational as well as contextual aspects must also be considered. For instance, patients' decisions might be influenced by experiences, such as past exposure to a parent suffering from cancer and the associated severe treatment side effects, whose exploration might modify their choices. To access such dimensions, relationship-building leading to a trusting relationship is as necessary as taking into account contextual factors, such as information from sources outside the medical universe, which can also influence choices on a point that one needs to reconsider if the decision is truly an "informed decision".

This finding is illustrated by the study of Thorne et al. [16], who systematically analyzed cancer patient perspectives and revealed how SDM requires relational engagement: *“Given the obvious importance for patients of such key features as being known, feeling informed, and nurturing hope, it becomes evident that the ‘rules of engagement’ in shared decision-making require that same level of individualized complexity”*. Swainston et al. [17], who longitudinally explored women’s lived experiences of breast cancer in relation to the treatment decision-making process over time, furthermore identified context-dependent factors, suggesting that the patient’s role in decision-making can vary between surgical and nonsurgical treatment decisions. The majority of women in their study reported a passive role in the surgical treatment decision-making process, leaving the decision to surgeons, but they adopted this stance consciously and were therefore not disengaged from the process. The spectrum of patients’ ambivalent stances, expressed by the negotiation of responsibility for treatment decisions, is illustrated by Sinding et al. [18], whose findings revealed that *“being positioned as decision makers is a felt entitlement for (some) women with breast cancer, and is, at the same time, something they resist, reframe and work to reconfigure”.* Based on a triangulation of consultations with breast cancer patient and surgeon perspectives, Mendick et al. [19] also concluded: *“what patients seek is necessarily subjective as well as contextually and relationally bound*”.

3.3. The patient

What appears as a central element in decision-making has general relevance: patients are unique, singular individuals, and a “one-size-fits-all”, standardized approach does not fit in regard to communication.

Le Blanc et al. [20], who interviewed patients with acute myeloid leukemia, indeed observed that clinical context is *“sometimes complicated by a mismatch between patients' informational preferences* *and clinicians' communication styles […]".* This result has been confirmed by studies with patients affected by advanced cancer, as illustrated by Brom et al. [21], who examined mechanisms in daily oncology practice that can contribute to the continuation of chemotherapy, finding that *"(1) 'presenting the full therapy sets the standard,' (2) 'focus on standard evaluation moments hampers the evaluation of care goals,' (3) 'opening question guides towards a focus on symptoms,' and (4) 'treatment is perceived as the only option'."* These authors linked these mechanisms to routine clinical work, which hampers a more reflective conversation with each patient about his care goals, despite *"the emphasis that has been put on the importance of shared decision-making and advance care planning in the past decade"*.

Nissim et al. [22], who explored the experiences of diagnosis and treatment of patients with acute leukemia, revealed that patients' desired key elements of clinical communication at the opposite of standardization; in their study, one of the most important characteristics of care identified was "*the sense of trust in the medical team*", which the authors attributed in particular to the "*perceived expertise*" of the treatment team and "*the authentic human connection*" felt by the patients. Patients thus tended to consider their health care providers as emotional attachment figures. Thorne et al. [23], who documented the way in which communication has to be adapted to the stage of disease, stated that *"patients expect individualized approaches to communication that account for the distinctive contextual, disease and human attributes they bring to their cancer experience*". All these studies illustrate that "*significant communications occur within the context of the human connections associated with effective health care relationships*" and require "*'clinical imagination' with which to refine and expand a communication skills repertoire"* [23].

3.4. Relationship building

To reach out to individual patients presupposes the building of a trusting relationship; as stated by Step et al. [24], who examined challenges in communication about cancer recurrence, clinical communication *"can reflect a nuanced dance involving clinical information, conveyed support, patient preferences, family caregiver dynamics, and transformed expectations for both the patient and doctor".*

A trustful relationship, based on such a "nuanced dance", is indeed what patients value, especially those with advanced cancer. This finding has been confirmed by Schildmann et al.'s study [25], based on qualitative interviews with pancreatic cancer patients about their perceptions and views on information and treatment decision-making, which showed that trust outweighed the need for information.

However, the keys for establishing trusting relationships remain to be identified. A few studies address this issue and reveal surprising findings. Salmon et al. [26], who analyzed audio-recorded consultations and contrasted the results with data from interviews with patients and surgeons about their perceptions of the consultation and each other, revealed that *"for both patients and surgeons, the clinical relationship was emotional in that it went beyond technical care and encompassed surgeons' personal character and their emotional support of their patients"*. The authors also underline that *"an emotional relationship did not require overt emotional talk"* but did require qualities such as expertise and authenticity.

Furthermore, the relational context of the patient also appears to play a role in communicating sensitive issues between patients and significant others, as illustrated by Ngwenya et al. [27], who investigated disclosure and privacy when sharing news of lung cancer with their family and friends. They found that patients believe that they should control the flow of the provided information and concluded that their result *"points to the importance of the relational model within healthcare"*, a model that also acknowledges the role played by significant others in the patients' health and wellbeing.

3.5. Communication barriers

One can assume that both clinicians and patients desire adequate communication and trusting relationships; nevertheless, this seems to not be an easy task in daily clinical practice, as demonstrated by qualitative studies focusing on individual, institutional or societal communication barriers.

In their observational study on communication about life expectancy with advanced cancer patients, Henselmans et al. [28] observed that *"it was consistently either the patient or the companion who raised the subject; oncologists never volunteered to provide prognostic information"*. In addition, oncologists showed a tendency to focus on the "optimistic scenario", which points to possible inner barriers of clinicians. Focusing on optimistic scenarios cannot be considered as maintaining hope when it corresponds more to the needs of the physician than those of the patient. These inner barriers may be due—as revealed in a study by Horlait et al. [29], which aimed to identify the barriers to introducing palliative care among patients with advanced cancer—to representations, for instance, of the concept of "palliative care". This concept is still too often thought of as being *"the very last option once patients have exhausted all potentially curative or life-prolonging treatments and have reached the terminal phase of their disease"*.

Structural barriers also exist, as identified by Dencker et al. [30], investigating communication with seriously ill patients about their dependent children. They indeed found that elements such as *"lack of space in the medical record system, professional code, time pressure, and lack of training"* constitute significant barriers. Interestingly, the authors observed that due to the emotional distress caused by the situation and the perceived necessity to keep control and maintain professional distance, these barriers were not challenged by the healthcare personnel. This result was also found in the phenomenological study by McLean et al. [31] about the communication experiences of doctors and nurses in a cancer unit, which showed *that "they control the level of intimacy with patients in order to protect themselves from emotional distress".* This study also found that the need for control results in a focus on the more technical aspects of care and in *"a tension between maintaining emotional distance yet having level of relationship with patients"*.

Moreover, Nguyen et al. [32], in their qualitative exploration of the clinicians' perspectives on patient- and family-centered care (PFCC), found that *"oncologists perceive diverse barriers to practicing PFCC at both system and provider levels"*. However, as highlighted in the study by Goossens et al. [33], exploring communication difficulties and the experience of loneliness among patients with cancer dealing with fertility issues, oncologists' communication behavior was characterized by an "*emphasis* *on positive thinking, one-sided focus on cancer survival*". Here again, positive thinking reflected a need of the physician and not of the patient.

A key to understanding these findings may be that awareness of structural barriers may not lead to change as long as psychological barriers persist, as suggested by the results of Rodenbach et al. [34], who examined how oncology clinicians' perspectives about how their own life and death affect and are affected by their care of and communication with dying patients. These authors conclude that *"most oncology clinicians express a conditional acceptance of their own death, and for many, there is a reciprocal relationship between their attitudes toward their own death and their care of dying patients*".

To return to the question of how to train oncology clinicians, this question underlies many of the qualitative studies of our dataset, but was specifically addressed by only a few.

3.6. Clinical communication training

Many CST programs for oncology clinicians are based on learner-centered and experiential methods. However, qualitative studies addressing the issue of pedagogic approaches confirm the need for new pedagogic methods, complementing traditional CST approaches, and warn against one-size-fits-all training methods.

Mendick et al. [35] investigated how surgeons thought that desirable communication arose and reported that *"surgeons generally thought that what they learned from formal training was artificial", and "they primarily described communication holistically, referring to their personal aims and style".* The surgeons also considered that part of the learning process is related to *"being attentive to patients and curious about them, and aware of their own behavior and feelings"*.

Back et al. [36], who aimed to characterize the way oncology fellows conceive of communicating transitions in goals of care, observed that they either relied on a logical frame (based on a biomedical orientation to disease) or on an experiential frame (based on the patient perceptions of the illness experience). The authors hoped that their *findings "may enable clinicians to become more aware of* *their own patterns of communicating transitions, which might enable them to try a new direction when they find themselves getting stuck […]".* This study demonstrates that clinicians' use of a given frame was based on a one-size-fits-all approach, irrespective of the patients' preferences, and calls for methods that have the potential to raise awareness of their own communication styles and the underlying needs they fulfill. In other words, training has to focus on insight and must therefore address the clinician's "inner" world, as well as the contextual constraints, be they institutional or social, that influence communication behavior [37].

Finally, Bibila et al. [38] identified different needs of CST participants depending on professional backgrounds and stressed the impact of depths of professional experiences on training dynamics, which can be fueled by competition or hierarchy issues between participants.

4. Discussion and conclusion

4.1. Discussion

A critical appraisal of qualitative inductive research on communication in cancer care reveals that multiple factors shape the communication between clinicians and patients: the different functions and effects of information provision, the relational and interactional aspects of communication, its patient- and context-related dimensions, and the inner and outer barriers hampering the patient encounter that clinicians are facing.

Putting these findings into perspective with regard to training in communication in the oncology setting, significant questions emerge. Are these findings relevant for training? If so, how can they be translated into a training program, and with what kind of consequences for the design of new training approaches?

From a relevance perspective, the outlined findings echo the aforementioned concerns with regard to CSTs, which are criticized for being based on expert opinions, somehow neglecting the clinical reality of the practice of oncology [4]. The studies included in this work reveal that clinical communication cannot be considered an activity defined by a set of universal rules. In contrast, clinical communication appears to be interactional, patient-dependent, and context-dependent and to be shaped by the inner and outer worlds of clinicians. As a consequence, there can be no standardized, one-size-fits-all communication and, ultimately, no standardized, one-size-fits-all communication training program. This statement seems somehow unrealistic since standardized training has the advantage of being easily implemented for a large number of participants.

4.2. Conclusion

A possible way to achieve both goals, to reach all oncologists and to provide training centered on the singular needs of participants, is a shift in the focus of training from communication tasks or communication-related situations to the clinician. Specifically, training should focus on the competencies and qualities to be developed by oncology clinicians, such as being flexible, able to adapt to the singular patient, sensitive to interactional aspects of communication and increasingly aware of the inner and outer barriers, which influence the clinical encounter.

4.3. Practice implications

The identified challenges can be addressed in clinician-centered training. In fact, perception of patients' needs requires some basic knowledge about humans' psychological functioning when facing cancer, be it as a patient or as a caring clinician, and how it can be identified in the context of clinical interaction. This goal can be achieved mainly by methods that enable or enhance introspection. Emotions, perceptions and attitudes, which potentially erect barriers between the clinician and the patient, as well as outer barriers, utilized for defensive purposes by clinicians, can be addressed and modified by means of methods facilitating introspection, such as individual and group supervisions or Balint-inspired groups [39]. Such a clinician-centered approach, which has recently been endorsed by the third European consensus meeting on communication in cancer care, has the concurrent advantages of (i) being generic, in the sense that it is not a situation-specific approach, multiplying training methods related to different topics; (ii) stimulating a reflective process, which benefits the clinician and the patient; (iii) directly addressing participants' individual resources and possibilities; and (iv) limiting the amount of predefined communication behaviors to be acquired.

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