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Are future medical oncologists sufficiently trained to communicate about palliative care? The medical oncology curriculum in Flanders, Belgium

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Background: Palliative care is considered an integral part of oncology and communicating this with patients is an unavoidable task for oncologists. This contribution investigated to what extent communication skills for communicating palliative care with patients are trained in the formal academic training program in medical oncology in Flanders, Belgium. The programme is based on the recommendations for a Global Core Curriculum in Medical Oncology, developed by The American Society of Clinical Oncology (ASCO) together with the European Society for Medical Oncology (ESMO).

Methods: For this qualitative study, data were collected using document analysis from the ESMO/ASCO recommendations and the documents of the Flanders' medical oncology programme complemented with interviews with Flemish medical oncology trainees.

Results: Few recommendations for training communication skills to communicate about palliative care were found in the ASMO/ASCO recommendations and even less in the Flanders' programme documents. Trainees are mainly exposed to palliative care communication during the clinical practice of their training. Only very few lectures or seminars are devoted to palliative care and even less on communication about palliative care. They reported several barriers to communicate about palliative care.

Conclusions: This study revealed promising developments for the training of Flemish medical oncologists to discuss palliative care. However, there is still a need for more theoretical training on palliative care complemented with communication skills trainings. Communication training in general needs to be fully integrated as a core skill within the medical curriculum at large and should be promoted as lifelong learning and competency development.

Keywords: Communication, Palliative care, Medical education, Medical oncology, Qualitative research

Introduction

The joint Recommendations for a Global Core Curriculum in Medical Oncology by The American Society of Clinical Oncology (ASCO) and the European Society for Medical Oncology (ESMO) list the range of competencies for trainees to qualify as medical oncologist.¹⁻³ One of the domains concerns communication. Effective communication refers to the dialog between the patient and the physician where information is tailored to the needs and preferences of the patient. It encompasses a non-verbal component and adequate recognition of the patients' emotions or discomfort and addresses psychosocial, spiritual or existential needs. Neither party is restricted from voicing their opinion, questions or concerns.⁴

Effective communication skills from the oncologist are considered as a prerequisite for qualitative and comprehensive oncological care.^{5,6} Training oncologists by communication skills trainings (CST) is a promising approach to acquire these skills.^{7,8} Arguments are developed that CST should be learner centred, flexible, engaging, and instructive through interactive learning forms such as role-play in small groups supported with video recording in a safe, simulated setting allowing reflection, immediate playback and feedback. CST should also be organised in modules in breaking bad news and discussing unanticipated adverse events, discussing prognosis, reaching a shared treatment decision, responding to difficult emotions, coping with survivorship, running a family meeting, and transitioning to palliative care and end of life.⁹

The timing of CST is important. Ideally, CST should begin at the graduate level and should continue throughout clinical practice in order to continuously strengthen

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and improve a health care professional's communication skills.⁸

Although one can find rather clear arguments for CST in literature, research also indicates that oncologists receive very little formal training and education to develop adequate communication skills.^{5,10–13} Furthermore, very few guidelines or recommendations on how these skills can be enhanced are documented. An exception is the Swiss Cancer League that organised a consensus meeting in 2009 with European opinion leaders and experts in the field of CST, as well as oncology clinicians, representatives of oncology societies and patient organisations. On the basis of a systematic review and a meta-analysis, recommendations have been developed for the provision, future development and evaluation of CST in oncology.¹⁴

A particular challenging issue in oncology is palliative care.^{15–17} Communicating with patients about palliative care is a core task for the oncologists. Palliative care is recommended to be implemented early in the cancer trajectory, preferably from the moment of cancer diagnosis onwards, to improve patients' quality of life (QOL) at different stages of the illness.^{18,19}

This contribution focuses on the question to what extent communication skills for discussing palliative care are acquired in a formal academic training program in medical oncology in Flanders, a part of Belgium. In Belgium, medical oncology was officially recognised as a distinct specialty in 2007. The four main universities of Flanders (Antwerp, Brussels, Ghent, Leuven) developed a Master after Master programme for medical oncology. The programme took into account the ESMO/ASCO recommendations.

Methods

Qualitative data were collected using document analysis, interviews and group interviews. The document analysis served as background to understand the experiences of medical oncology trainees. These experiences were collected through interviews and group interviews.

The document analysis included the first^{1,2} and second version³ of the ESMO/ASCO recommendations and the associated logbook.²⁰ It focuses on the question whether there are formal recommendations for training communication skills specifically for palliative care. The Logbook (of which only one version exists) was included as it serves as a checklist to keep record of the oncology trainees' educational programme, their progress and as a tool for supervisors to assess trainees' performance.

Additionally, we analysed the documents of the Master after Master medical oncology program in Flanders drawn up in 2007 and 2015 by the program directors of the four main universities (Antwerp, Brussels, Ghent, Leuven) focussing on the same question.

All documents were independently screened by MH and ML. In an iterative process, all text passages referring

implicitly and explicitly to 'communication' and 'palliative care' were extracted.

In the second phase, we conducted individual and group interviews recruited from the medical oncology trainee cohort of 2014–2016, in total 45 students. We explored respondents' experiences with the training of communication skills to discuss palliative care. The participants completed 7 years of basic medical training followed by three years of internal medicine. At the moment of participation, they were enrolled in the Master after Master medical oncology program in one of the four main universities of Flanders.

For the individual face-to-face inductive interviews, we used open-ended questions structured around three major themes; (1) the perceptions of the trainees on their formal education in communication about palliative care, (2) their experiences with palliative care communication during clinical practice and (3) their education needs for communication about palliative care. All interviews were conducted in Dutch and transcribed verbatim. One of the authors (MH) independently coded the transcripts using open and axial coding²¹ with the qualitative data analysis software NVIVO v10. Researcher triangulation and cross-comparative analysis of the transcripts were realised with the coauthors, with expertise in oncology and social sciences.

As part of methodological triangulation, the (preliminary) analysis was subsequently validated in an additional round of data collection; we conducted one individual interview and two double interviews with medical oncology trainees to validate the preliminary analysis and reach data saturation.

Results

Results of the document analysis

Tables 1–3 present the findings of the document analysis of ESMO/ASCO recommendations.

Four recommendations refer to communication in the first edition of the ESMO/ASCO recommendations, using verbs such as 'discuss', 'communicate' and 'counsel'. The logbook mirrors the first edition (Table 1).

None of the recommendations focuses on communication about palliative care. One quote, however, implicitly refers to this competency: 'the trainees should be able to communicate with the patient and his family. They should be able to break bad news and act adequately in difficult situations.' (p.1608 – heading 'palliative care and end-of-life care – communication').

The second edition contains 20 recommendations for training communication skills (Table 2).

Six of these recommendations refer to communication about palliative care. Remarkably, the recommendations use the term 'end of life' rather than 'palliative care'.

The first edition of the Flanders Master after Master educational programme for medical oncology contains seven guidelines for training in communication (Table 3).

Table 1 Recommendations referring to communication in the first edition of the ESMO/ASCO recommendations (2004) and the ESMO/ASCO Log Book (2009)

Recommendations for training communication skills in the first edition of the ESMO/ASCO recommendations (2004)	Recommendations for training communication skills in the ESMO/ASCO recommendations Log Book (2009)
‘the trainees should be able to communicate with the patient and his family. They should be able to break bad news and act adequately in difficult situations. The trainees should learn to communicate and work together with other professional health care professionals in a team (e.g. nurses, social workers, psychologists)’ (p.1608 – heading ‘palliative care and end-of-life care – communication’)	‘communication with the patient and family’ ‘break bad news’ ‘act in difficult situations’ ‘communication and work with other health care professionals’ (p.20 – heading ‘palliative care and end-of-life care – communication’)
‘for each specific disease, the trainee should know the epidemiology, pathophysiology, genetics, signs and symptoms, diagnostic work-up, treatment and follow-up. The trainee should be able to communicate and discuss these topics with the patients’ (p.1608) ‘the trainees should be able to communicate with patients and their family. They should be able to break bad news and act adequately in difficult situations. Trainees should learn to communicate and work together with other professional health care takers in a team’ (p.1612 – heading ‘psychosocial aspects of cancer’)	‘for each specific disease, the trainees should know the epidemiology, pathophysiology, genetics, signs and symptoms, diagnostic work-up, treatment, and follow-up. The trainee should be able to communicate and discuss the topics with the patients’ (p.21) ‘communication with the patient and family’ ‘break bad news’ ‘act adequately in difficult situations’ (p.35 – heading ‘psychosocial aspect of cancer’)
‘the trainee should be capable of counselling the patients and their family about known risk factors for subsequent malignancy: diet, smoking, alcohol, and sun exposure’ (p.1612)	‘counselling the patients and their family about known risk factors for subsequent malignancy’ (p.36)

Table 2 Recommendations referring to communication in the second edition of the ESMO/ASCO recommendations (2010)

‘the trainee must be given the opportunity to assume the continuing responsibility for both acute and chronically ill patients in order to learn the natural history of cancer, the extent of the effectiveness of the various therapeutic programs, and how to impart information to the patient, including bad news’ (p.14)
‘they should be able to counsel these patients and provide advice regarding wigs, scarves and other head coverings’ (p.19)
‘trainees should be able to counsel patients and their families regarding the risks of infertility or sterility secondary to cancer treatments’
‘they should facilitate open communication regarding sexuality and offer counselling including discussion of possible interventions’ (p.22)
‘they should know and be able to communicate to patients preventative and/or treatment measures, and should refer patients to lymphoedema clinics when necessary’ (p.22)
‘trainees should be familiar with approaches to prevent constipation, provide supportive counselling and prescribe rational pharmacotherapy for the treatment of constipation’ (p.26)
‘trainees must be skilled in effective and compassionate communication with cancer patients and their families regarding diagnosis, treatment, prognosis, potential risks and toxicities and end of life care and death’ (p.27)
‘trainees should be able to discuss specific cultural-based preferences with patients and their families’ (p.27)
‘trainees should be able to discuss discontinuation of antineoplastic therapies, transitions in care, the anticipated clinical course, signs and symptoms of imminent death and the strategy to ensure optimal patient comfort as well as family support’
‘they should be aware of options for end-of-life care including home-based care, inpatient care and hospice care and should be able to help negotiate care preferences with the patient and their family’ (p.28)
‘for each specific disease, the trainee should know the epidemiology, prevention, pathophysiology, genetics, signs and symptoms, diagnostic work-up, treatment, follow-up, supportive and palliative measures. The trainee should be able to communicate and discuss these topics with the patients’ (p.28–29)
‘trainees should be able to advise patients to change lifestyle to better tolerate treatment and to reduce incidence of second tumours’ (p.29)
‘trainees should have a working knowledge in the primary prevention of melanoma as well as the recognition and counselling of patients at high risk of developing melanoma’ (p.34)
‘trainees should be capable in communicating the diagnosis, in treating and psychosocially supporting and caring for adolescents’ (p.38)
‘trainees should acquire theoretical background knowledge and clinical experience in the following aspects of cancer in young adult patients (age group 18–39): psychosocial counselling and support, communication with the patient and evaluation of prognosis, advise on future childbearing and patient counselling on healthy lifestyle modifications’ (p.38)
‘patient and family counselling on issues such as management, toxic effects, disease control, foetal outcome, breast feeding and future pregnancies’ (p.39)
‘trainees need to learn how to inquire about religious and spiritual beliefs and provide appropriate referrals’ (p.39)
‘trainees should develop competence in conducting a family meeting and providing clear guidance about end of life care’ (p.39)
‘trainees should develop mastery in communication with patients and their families. They should receive instruction as well as coaching and feedback in the areas of collaborative decision-making, breaking bad news, discussing prognosis and goals of care’ (p.40)
‘communication skills training has been shown to be effective to improve skills if the training is learner centred, use role play and structured feedback, and is conducted in small groups by trained facilitators. Follow-up supervisions and booster sessions are recommended’ (p.40)
‘the trainee should be capable of counselling the patients and their family about known risk factors for subsequent malignancy: diet, smoking, alcohol and sun exposure’ (p.40)
‘trainees should be able to discuss an approach to end-of-life decision-making with capable people including advanced care planning and working with substitute decision makers for those who are incapable. Trainees should be able to discuss ethical and legal issues relevant to euthanasia/assisted suicide’ (p.41)

Table 3 Recommendations referring to communication in the documents of the Flanders educational programme for medical oncology (2007)

'the communicator communicates clinical information (oral and written) to patient/family' (p.3)
 'communicates correctly and in an human-empathetic manner with the patient and his or her environment' (p.4)
 'the physician specialist in medical oncology has the necessary communication skills where human, ethical and social aspects play an important role and within the relevant legal regulations' (p.4)
 'the physician specialist in medical oncology communicates medical and scientific information effectively' (p.5)
 'as a starting trainee he/she should communicate effectively with patient, family and other health care providers' (p.7)
 'policy skills: communication' (p.10)
 'The medical oncologist is able to communicate in an honest, fair, humane and empathetic manner with the cancer patient, his family and environment. He/she is also able to do this in terms of diagnosis, treatment options and prognosis of disease.
 In his work environment, he/she is able to communicate effectively with colleagues, team members, captains, media, etc. ...' (p.17)

One guideline refers implicitly to communication about palliative care. Quite surprisingly, no guidelines to train communication skills were found in the second edition of the programme.

Results of the interviews

Nine medical oncology trainees (two men and seven women) were interviewed in the first round, aged between 28 and 32 years (average 29,5 years). Five were enrolled in their first year of the medical oncology training program, one in the second year and three in their third and last year. On average, the interviews lasted 47.25 min (range from 31 to 59 min).

In the validation round, five medical oncology trainees were interviewed (three men and two women) aged between 28 and 30 years (average age 29,4 years). Two trainees were enrolled in the first year of the programme, two in the second year and one in the last year. Interviews lasted on average 79.34 min (range from 58 to 115 min).

The formal training trajectory

In Belgium, the basic medical education lasts for 7 years. The first three years lead up to a Bachelor’s degree, followed by a four-year Master’s programme. Graduates who wish to pursue a career in medical oncology first enrol for 3 years in the internal medicine program and finish their last 3 years in a medical oncology programme before becoming a certified medical oncologist.

The trainees reported that lectures are the major teaching format in the basic medical education program. Some lectures addressed theories and general models for communication in medicine. Very few lectures are devoted to palliative care, and if so, only from a medical, pharmacological perspective for pain and symptom management. Lectures are complemented with small-group skills trainings mostly in the form of role plays with actors for bad news conversations or consultations with ‘difficult’ patients. No role plays were specifically dedicated to palliative care. Years 6 and 7 of their programme include clinical internships at different hospital departments. During these internships, they are assigned to a formal supervisor, but trainees collaborate with other attending physicians too. Trainees are expected to

acquire communication skills by observing supervisors and attending physicians. Opportunities to observe palliative care conversations are inconsistent though and depend largely on the department and on the supervisor/attending physicians.

The internal medicine programme focusses more on (clinical) skills training than on theoretical knowledge. Educational time is almost entirely devoted to clinical practice at different internal medicine departments. Lectures, seminars or workshops are limited. Some workshops or seminars tackle communication in general but rarely on communicating about palliative care. From the start, trainees participate in all medical activities, including individual and independent communication with patients. The respondents frequently had to do bad news conversations, sometimes on palliative care.

During the medical oncology programme, communication with patients about palliative care frequently occurs. Each trainee must work a period on an inpatient palliative care department where such discussions are daily business. These conversations are solely conducted. Moreover, they receive little formative feedback on their communication skills. The lectures or seminars do not particularly focus on palliative care or communication about palliative care.

Experiences with communication about palliative care

Most trainees acknowledged that communicating about palliative care is often difficult, especially as a beginning trainee. More communication support would certainly help them. The majority however, considered communication as their ‘logical’ obligation and part of their medical responsibility, and their muddle through.

Figure 1 differentiates the reported barriers to communicate palliative care in levels: (a) the individual, including the characteristics of patients, family or peers and the trainee; (b) the interaction; (c) disease or treatment; (d) organisational characteristics and (e) broader society (Table 4).

Trainee. An introvert personality or a hesitant communication style of the trainee may hinder the trainee to initiate the discussion about palliative care.

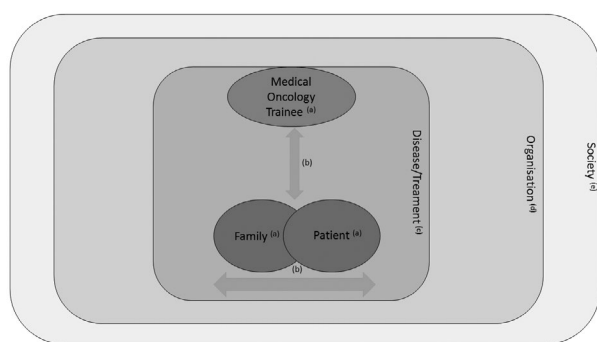


Figure 1 Context for communication about palliative care.

The nature of the conversation can have an emotional impact that influences communication; bringing up palliative care can sometimes initiate a feeling of personal failure or nurture fear of depriving hope from the patient. Especially workdays where trainees have several conversations with different patients about palliative care can induce emotional strain (see also infra).

Trainees’ feelings of anger or sadness emerge as potential barriers to communication. For example, anger develops when a discussion is not successful or if patients react in anger. Trainees’ sadness can occur by the mere fact that that curation is not an option.

Initiating difficult conversations about palliative care is difficult, also because cancer is such a complex disease. A lack of experience with cancers and lack of expertise and experience about prognosis is mentioned as a barrier,

mainly by trainees in the first year of the medical oncology program.

Patient. Meaningful and sensitive conversations about palliative care in another language than the mother tongue are considered as very difficult. Moreover, age is sometimes experienced as a barrier, particularly if the patient is about the same age as the trainees. It also is difficult to discuss palliative care if patients have unrealistic hope, expectations to survive or about the potential for cure making.

Trainees mentioned sadness, denial, anger and verbal aggression of patients as thwarting communication. Emotions can impede the patient to absorb information. Rejecting or denying bad news is a potential hindrance for the trainee to raise the issue of palliative care.

Interactions. Some communication barriers are inherent to the interaction between the trainee and the patient. A ‘personal mismatch’ of trainee and patient challenges good communication. Moreover, an emotional bond resulting from long interaction and/or if trainees know a lot about the patients personal situation makes introducing the subject of palliative care more difficult. In contrast, some trainees also mentioned the difficulty to raise the topic if they do not know the patient at all, for example in a first consultation.

Trainees were generally positive about the presence of a relative, as it supports yielding information. However, relatives can impede to talk about palliative care, as they want to protect the patient from information considered as

Table 4 Perceived barriers to communication about palliative care

Medical oncology trainee (a)	Individual traits	Introvert personality Hesitant communication style
	Emotional impact	Feeling of failure Fear to deprive hope Emotional fatigue Own emotions
	Experience	Understanding of the disease Uncertainty about prognosis
Patient (a)	Individual traits	Language Age Unrealistic expectations
	Emotional reactions	Frustration/anger/verbal aggression Sadness/fear Emotional blockage Denial
Interactions (b)	Trainee patient	Emotional attachment First consultation
	Trainee patient family	Personal mismatch Emotional protection Unrealistic expectations
Disease/Treatment (c)	Disease trajectory	Unpredictable evolution Previous discussions
Organisation (d)	Practicalities	Lack of time Lack of space/disturbing telephone
	Workload	Combination residency and educational activities Patient load
	Position trainee	Trainee is not the treating physician Attending physician does not discuss palliative care
	Support	Lack of support/coaching Lack of formal feedback
Society (e)	Palliative stigma	Negative connotation Misunderstanding concept palliative care

painful or because their expectations about curation makes them avoid the topic of palliative care.

Disease development and treatment options. The unpredictable development of some cancers has frequently been cited to avoid (early) discussions about palliative care. The complex nature of cancer makes prognosis difficult or the impact of the treatment unpredictable. Moreover, palliative care is not a single-shot issue but part of a trajectory in which disease development is discussed in recurrent consultations. If previous discussions (whether or not about palliative care) have not been perceived as successful, trainees might be discouraged to initiate the topic of palliative care.

Organisational factors. Many participants pointed at organisational factors, in particular the lack of time to discuss palliative care. A lack of time is strongly related to the workload on the ward (both length of workdays and number of patients) that has to be combined with educational activities. Often, the time issue interact with a lack of available space to quietly and openly talk without being disturbed by incoming phone calls. It sets the stage for emotional exhaustion over time and has an impact on committing to communication.

The role and position of a trainee within the organisation can have an impact on communication. Trainees report a strain between high job demands and low job control, which induces stress. They mentioned in some hospitals a lack mandated autonomy to make (medical) decisions related to palliative care. Some trainees also reported about the attitude and behaviour of attending physicians who avoid discussing palliative care with patients hampering the trainees' motivation to engage in it.

Trainees report that neither attending physicians, nor supervisors did observe them while communicating with patients. Some mainly focus on clinical matters neglecting the evaluation of communication skills. Trainees all experienced a lack of organised support, in particular after highly emotional conversations such as palliative care.

External societal factors. Trainees report that palliative care in the society in general still is mainly associated with terminal care, death and giving up hope, which makes patients, families and even physicians avoid raising the topic. The association with 'death' hampers to openly use the word 'palliative'.

Perceived education needs for communication about palliative care

All interviewees recognise that CST, if any, is not sufficiently focussed on oncology and even less on palliative care. Besides 'hands-on' training, trainees experience a need for 'theoretical' lectures on palliative care, ideally starting in the second last and final year of the basic medical education program.

Trainees express a need for formal feedback (super- and 'interview') on how palliative care is discussed with patients. They plea for small group discussions or 'team

interview' in addition to supervision and expect continuous monitoring and formative evaluation of their communication skills. The current personal Assessments using a simple checklist do not promote a personal development or a positive attitude over time.

A further need is the protection of 'learning time'. Being fully integrated role as a physician on the ward with long working hours and night and weekend shifts, impedes spending time on educational activities. Moreover, they experience feelings of letting down their colleagues when they have to leave for courses or trainings and often (depending on the hospital) experience very little support of their supervisors to participate in training activities.

Discussion

This study investigated to what extent future medical oncologists are sufficiently and adequately trained to communicate palliative care with patients (and their families). A growing amount of evidence shows the importance of good communication skills for oncologists.^{5,22} It enables the oncologist to detect patient distress⁵ and to effectively assess and manage pain,²³ anxiety and depression.²⁴ Effective communication skills are also essential for patients to understand their prognosis to make treatment decisions based on realistic expectations.²⁵ We found that very few of the guidelines in the ESMO/ASCO recommendations refer to communication about palliative care. The key goals of conversations about palliative care is to communicate information about palliative care, explain the incurable nature of the disease and exploring the patients' preferences and priorities regarding further treatments and end-of-life issues. During this process, communication should be in line with their readiness and with attention to their concerns and fears. This requires specific skills. Currently, medical oncology trainees are mainly exposed to palliative care communication during the clinical practice of their training programme. Only very few lectures or seminars in the medical oncology programme are devoted to palliative care and even less on communication about palliative care.

But there are promising indications of change, if we compare with the findings of Horlait et al.¹³ showing that an 'older' generation of Flemish oncologists received little or no training in communication at all. This study indicates a growing awareness among the 'next' generation of oncologists about the importance of effective communication and about palliative care. The joint ASCO/ESMO recommendations may have served as a trigger in this process, as they were translated in medical oncology programme in the Flanders Master after Master medical oncology programme.

The findings also indicate that communication skills are acquired over a longer period of time and that communication should not be considered as an 'additional' competency to be learned as a one-shot learning exercise. Communication training needs to be adapted to clinical

experience. Therefore, we would support the idea for ASCO/ESMO to develop more precise recommendations on communication in general as well as on communication about palliative care.

Flemish oncology trainees express a need for more formal theoretical training on palliative care complemented and integrated with ‘hands-on’ communication skills trainings adapted to the learning trajectory and level of practical experience, even beyond the Master after Master programme. In this perspective communication, training in palliative care is closely connected to other situations in which difficult emotional situations with patient and families have to be handled and can be integrated in an overall communication training approach. Apparently, the participants of this study do not feel fully equipped for this job, as they do not realise that the basic communication skills such as dealing with emotions, giving adequate, correct and understandable information, are useful for these situations. This conclusion also fits with previous findings that without continuous training, communication skills deteriorate over time.^{26,27} Moreover, continuous opportunities for tailored feedback and formative evaluation (supervision and ‘intervention’) should be built in the learning trajectory to enhance the learners’ knowledge, skills and professional performance.^{28–30}

Training recommendations should also address organisational conditions (in terms of tasks, workload and organisational culture) for trainees to acquire communication skills. Long work hours, significant workload and performance pressure from the hospital hampers time spent and motivation to participate in educational activities³¹ also because trainees experience a strong sense of commitment and responsibility both to patients and to colleagues.^{31,32}

Conclusion

The current research demonstrates a positive tendency concerning the issue of communication in oncological care. However, one still needs rather fundamental investments in upgrading the quality of communication skills of the oncologists. This will eventually improve the quality of oncological care. Formal medical education can certainly contribute to the enhancement of the skills, as was clearly expressed by the trainees, by adapting their training approaches with regard to communication in order to better address patients’ needs.

Ethics approval and consent to participate

Ethics approval for this study was given by the Medical Ethics Commission of the Brussels University Hospital (B.U.N. 143201318799) and the local Medical Ethics Committee of the University Hospital Ghent. All the participants were given assurance of confidentiality that the information gathered will be used exclusively for research purposes and informed consent of all participants was obtained prior to data collection.

Authors’ contributions

All authors were involved in the design of the study, data collection, analyses and interpretation. MH drafted the manuscript. SVB and ML critically revised the manuscript. All authors read and approved the final manuscript.

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Disclosure statement

The authors declare that they have no competing interests.

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