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Original Paper

Effective Communication Skills are the Key to Good Cancer Care

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Communication within oncology is a core clinical skill but one in which few oncologists or specialist cancer nurses have received much formal training. Inadequate communication may cause much distress for patients and their families, who often want considerably more information than is usually provided. Many patients leave consultations unsure about the diagnosis and prognosis, confused about the meaning of—and need for—further diagnostic tests, unclear about the management plan and uncertain about the true therapeutic intent of treatment. Additionally, communication difficulties may impede the recruitment of patients to clinical trials, delaying the introduction of efficacious new treatments into clinics. Lack of effective communication between specialists and departments can also cause confusion and a loss of confidence amongst the team. Oncologists themselves acknowledge that insufficient training in communication and management skills is a major factor contributing to their own stress, lack of job satisfaction and emotional burnout. Consequently, over the past few years there have been several initiatives aimed at improving basic communication skills training for healthcare professionals in the cancer field. In this paper, some of the issues that influence communication within an oncology setting, and ultimately affect patient care, are discussed. © 1999 Published by Elsevier Science Ltd. All rights reserved.

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INTRODUCTION

DOCTORS AND nurses usually talk and listen to patients more often than they perform any other single medical or nursing procedure. For example, during a clinical career spanning approximately 40 years, an oncologist is likely to conduct between 150 000 and 200 000 consultations with patients and their families. Thus, communication should be viewed as a core clinical skill that merits a considerable investment of time and resources in training. Unfortunately few oncologists or nurses have received adequate formal education in communication skills using methods likely to promote change, confidence and competence [1]. This is a serious omission as good communication has many positive effects on the patients' adjustment to cancer and its treatment, whereas poor communication has negative consequences for both healthcare professionals [2] and patients [3].

Effective communication during a consultation is probably the major determinant of the accuracy and completeness of the data collected. It influences the range and number of symptoms elicited, permits a more precise assessment of the efficacy of therapy, affects adherence to treatment recommendations, impacts on emotional and physical well-being and contributes to both patient and healthcarer satisfaction. There is compelling evidence from the literature demonstrating that good, patient-centred communication is associated with many important and meaningful health outcomes, including adherence to drug regimens and diets, pain control, resolution of physical and functional symptoms, improvements to physiological measures such as control of blood sugar and hypertension, and good psychological functioning of patients [4]. Trust in the doctor is a primary motivating factor in the acceptance of clinical trial participation [5]. The substantial clinical benefits that accrue from good communication should be sufficient argument for the inclusion of better training, and although most under-

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graduate curricula and postgraduate specialist programmes now make some reference to psychosocial issues and communication, often these are still considered somewhat peripheral topics.

Not surprisingly, many cancer patients are dissatisfied with much of the communication that takes place within hospitals. The omission of adequate information about the diagnosis, prognosis and potential therapeutic options can increase anxiety and uncertainty and can lead to dissatisfaction with healthcare in general [6]. Many of the complaints reported each year to the British National Health Service Ombudsman concern communication failures rather than technically negligent medical practice [7]. Litigation is more likely if doctor–patient communication has been poor [8]. These unsatisfactory circumstances are not only distressing for patients, but they are also professionally and personally unrewarding for the doctors and nurses involved [2].

The fundamental prerequisites for successful interactions between healthcarers and their patients are that the amount of information given is adequate, and that it is understood, believed, remembered and hopefully, acted upon. Sadly, many published studies reveal that these basic requirements are achieved infrequently. The reasons underlying poor communication are complicated. They involve both personality and attitudinal characteristics of patients and their healthcarers, together with difficulties created by the cancer care delivery systems.

PATIENTS' COMMUNICATION DIFFICULTIES

Lay populations often have less knowledge about basic biology and medical terminology than doctors and nurses realise, so patients may have genuine difficulty understanding what is wrong [9]. Anxiety about having a life-threatening disease can make interpretation and comprehension of complex information even more difficult. However, attempts to minimise anxiety are necessary and worthwhile otherwise patients may overestimate the seriousness of their condition [10]. For example, there is experimental evidence from cognitive psychology that the anxious person attends selectively to the information about life threat, recalls more of the information related to life threat than that related to other more neutral information and imposes more life-threatening interpretations on any ambiguous statements made by the doctor [11, 12].

Although patients should not be misled about the seriousness of their disease [13], many have overly negative and pessimistic views about the efficacy of modern treatments that need discussion. Patients are exposed repeatedly to television programmes and other media about cancer, where often the information portrayed is misleading and inaccurate. Considerable harm can be created by the misinformation arising from the specious articles and advertisements for miracle cures for cancer posted on the Internet. Communication with the overly informed—and sometimes misinformed—'internet patient' is an increasing problem mentioned by healthcarers.

Irrespective of the source of a patient's prior knowledge, healthcarers need to assess the patient's basic understanding of cancer, their expectations of what lies ahead and their information needs, if further communication is going to be successful [14]. Recall for medical information among hospital patients in general is rather poor, with a mean recall of around 54% [15]. When the consultation concerns cancer, then recall is approximately 25% [16]. In one report where oncologists rated their information giving as particularly good, patients still failed to recall important details about their diagnosis, treatment, therapeutic intent of treatment and prognosis [17].

It is difficult to predict which patient characteristics are most likely to aid information retention [10]. Age appears to have no consistent relationship [15, 18] and intelligence shows a weak but consistent relationship [15] with information recall. Interestingly, social class has little effect [18], despite the fact that doctors typically spend more time with, and give more information to, patients perceived to be from higher socio-economic backgrounds [19]. Likewise, the influence of mood state on information recall is complicated. Although anxiety and depression affect the recall and subjective comprehensibility of medical information in non-patient volunteers [10], other research with both patients and non-patients suggests that moderately high levels of anxiety may actually increase recall by motivating people to attend more actively [20].

A comprehensive review of the literature [20] revealed good evidence that the structure and content of the consultation influences the patient's ability to remember what has been said in several ways: (1) patients usually recall facts provided at the start of a consultation more readily than those given later; (2) topics deemed most relevant and important to the patient (which might not be those considered most pertinent to the doctor) are recalled most accurately; (3) the higher the number of statements made by a doctor, the smaller the mean percentage recalled by the patient; and (4) items that patients do manage to recall do not decay over time as do other memories—in fact, many patients have verbatim recall of what they believe the doctor to have said.

Few doctors recognise the different preferences that their patients have for both type and amount of information. The desire for more information is sometimes confused with a presumed wish to participate in clinical decision making [21]. In women with breast cancer, research has shown that the majority prefer a relatively passive role in decision making but require, nevertheless, a large amount of information regarding treatment options [22–24].

Several studies conducted in Europe and the U.S.A. [25–27], have shown that the overwhelming majority of patients wish to know if they have cancer, what are their chances of cure, and all the possible side-effects of treatment. Fewer doctors these days are reluctant to use the word cancer [28] but many still believe that such disclosure should only be made to those patients who actively seek it [29]. Unfortunately, unless invited to ask directly, patients rarely ask important questions [30]. Many assume that their doctors would tell them everything relevant, others worry about appearing foolish if they reveal their ignorance by asking questions, and some feel guilty about taking up too much of the busy doctor's time. The structure and content of consultations was studied in 117 patients who were either being told their diagnosis or that the cancer had recurred; patients were given few opportunities to ask questions and little time to respond when asked if they had understood the information conveyed to them [31]. Given that all of these consultations contained bad news, the minimal attention paid to the patient's psychosocial needs was also a disappointing revelation in the study.

COMMUNICATION PROBLEMS OF DOCTORS AND NURSES

Some doctors acknowledge that their own communication skills are limited and consequently abrogate much of the responsibility for information-giving to specialist nurses. There is, however, no evidence that nurses' skills are any better than those of doctors. Nurses often display similar distancing tactics and inappropriate interviewing behaviours [32]. Furthermore, contrary to popular belief, patients want to receive their diagnosis and information from the most senior hospital doctor, not a nurse [27].

Effective consultations with patients demand not only good communication skills, but also personal awareness of the likely barriers to effective communication [33, 34]. The context and content of communication in oncology can often generate challenging and highly charged emotions and some doctors exhibit a cold, professional detachment as a means of preserving their own emotional survival. Unfortunately, such distancing tactics are unhelpful and damaging to patients and their families. Furthermore, strategies such as these do not allow doctors to establish the kinds of satisfying therapeutic relationships that can make medicine so worthwhile [34]. An alarming number of oncologists become disillusioned with their work and show signs of burnout [35]. Research shows that clinicians specialising in cancer acknowledge that insufficient training in communication and management skills is a major factor contributing to their stress, lack of job satisfaction and emotional burnout [36, 37].

The tendency for healthcare professionals to underestimate the amount of information that patients require [38] has already been mentioned. Censoring of information given to patients is often done on an intuitive basis, with little attempt to discover systematically what patients actually do want, although questionnaires are available for this purpose. Undoubtedly talking about cancer can be stressful, but failing to talk openly due to a misguided assumption that no news is good news, or by using euphemisms, only serves to reinforce misunderstandings. "The malignant reputation of cancer is enhanced by the secrecy surrounding it" [39]. Many lay people still assume that the diagnosis of cancer heralds very unpleasant treatments followed by a universally gloomy outcome. The failure to be candid about the diagnosis not only impedes acceptance and adaptation but also fuels patients' fears that they must have an unspeakably horrible disease and future—"what is unspoken is unspeakable" [40]. Other problems are created by a policy of non-disclosure; if for example, as is common practice in many parts of Europe [29], the diagnosis of an abdominal cancer is avoided with euphemistic discussions about abnormal cells, ulcers, growths or blockages, then the only type of abdominal cancers that lay populations learn about are fatal, since the true diagnosis only emerges later when metastases appear. Those patients with cancer who survive, living happier lives, do not contribute the concept of successful surgical resection to public knowledge. Thus the newly diagnosed patient who realises that they have cancer may be even more apprehensive, as their only awareness of such malignancies would be of those who had died of the disease [41].

The manner in which information is given has just as important an impact on patient recall and understanding as the content. Non-verbal communication conveys a great deal to patients who may scrutinise their doctors and nurses for nuances of expression or demeanour. For example, an oncologist gave 40 women at high risk of breast cancer the results that their mammograms were clear. With half the group the oncologist assumed a worried affect and for the others, a non-worried affect. Results showed that the worried affect group recalled less information, thought that the situation was more serious, had significantly higher state anxiety scores and significantly higher pulse rates [42]. Attention to non-verbal communication, such as facial expression and tone of voice are very important if the correct message is to be conveyed.

SYSTEM CONSTRAINTS PRODUCING COMMUNICATION DIFFICULTIES

Many consultations take place in environments that are not conducive to the practice of good skills. Some hospital departments provide less privacy for intimate or distressing consultations than one would find routinely in the office of an accountant, bank manager or veterinary surgeon. Also, there are constant interruptions. During a research project in which patients were provided with tape recordings of their consultations, one doctor expressed surprise at how often his consultations were disrupted by the telephone ringing or by other healthcare professionals entering the room [43]. It is too easy to become inured to such things, but it can be humiliating for patients to be overheard, and frightening or embarrassing for them to be party to the private conversations of others. Insufficient privacy contributes to patient unease, and may increase the patient's incapacity to either comprehend or contribute to the consultation.

As throughput and the reduction of waiting lists are uppermost in management priorities, some oncology clinics are so time pressured that a truly patient centred dialogue is sacrificed in favour of the physical examination and a doctor-centred monologue.

COMMUNICATION IN MULTIDISCIPLINARY TEAMS

Another problem within oncology that impacts upon care concerns the quality of the communication within the multidisciplinary team. Poor communication between different specialists and departments can add to the confusion about the diagnosis, test results and management. Improvements in communication provided by a multidisciplinary team approach to cancer care may be shown, but such organisational structures are alien to many healthcare professionals [44], many of whom have been educated within a more hierarchical system. Until old practices are abandoned and different patterns of communication between healthcare professionals become established, the putative benefits will not occur.

Important information for the patient is often omitted, based on the assumption that someone else must have relayed the relevant facts at the appropriate times. This can be confusing and cause a loss of confidence in the team and provoke needless anxiety for patients; it is also frustrating for clinicians who may have to spend extra time communicating bad news or even quite basic information to an unprepared patient. Current research being conducted by the authors, examining how well the multidisciplinary team is addressing the informational needs of patients, gives cause for concern. Although there has been a major reorganisation of cancer services in the U.K. following the recommendations of Calman and Hine, little—if any—provision was made for retraining of staff in better management practices and communication [64].

COMMUNICATING ABOUT CLINICAL TRIALS

Good cancer care demands efficacious treatments tested in clinical trials. Unfortunately, the rate of patient accrual to trials is very low, delaying progress in research and the consequent introduction of new cancer treatments. Poor recruitment arises from many sources, including some of the system constraints of cancer care delivery, concern about ethical and medico-legal issues, and the personality factors and attitudes of both patients [45] and doctors [46, 47].

The reluctance of doctors to broach the subject of clinical trials with potentially eligible patients is probably a more significant deterrent than is patients' reluctance to participate [47, 48]. Conflicts are perceived between the role of clinician and scientist and some doctors express anxiety about the impact that the necessary disclosure of uncertainty might have on the doctor–patient relationship [46, 47, 49].

Demands for high throughput and cost-containment result in too many patients in busy clinics, with inadequate consultation time and insufficient support to explain trial details and to allow properly informed consent to be obtained [47]. Also, research has shown that some hospitals do not reward or encourage clinicians who join collaborative trials. Notwithstanding these constraints, a fundamental factor in poor trial recruitment comes down to the communication skills of doctors [5]. This also results in an unacceptably low understanding exhibited by patients about the trials they join. Trying to explain randomisation, giving complex information and obtaining informed consent were acknowledged as primary problem areas by 178 senior oncologists attending courses on communication skills [1]. Discussing trials is not easy and doctors, nurses and trial co-ordinators who have that role, need more education and understanding about patient attitudes, as well as help with their communication skills, if the situation is to improve [50].

The primary reasons why patients may decline entry into a clinical trial include: concerns as to whether or not the best available treatment would be given (even though trial participation usually leads to better health outcomes) [51], a preference for the doctor to choose a specific treatment arm rather than be randomised [52], the type of trial on offer [5], and fear of severe side-effects [53]. Poor understanding about the purpose and value of clinical trials has led to suspicion and confusion among the general population [54, 55]. In addition, considerable ignorance abounds concerning the meaning of randomisation; some patients are worried about the process, preferring the doctor, whom they trust, to make treatment decisions rather than to leave this to a computer and the play of chance [56]. In a recent survey lay people were given seven different statements explaining randomisation; the less explicit explanations which played down the role of chance were favoured [57]. These opinions were from a non-sick population; whether they apply to patients with cancer has yet to be formally tested. Doctors need to be aware of these issues and to ascertain their patients' understanding about randomisation and trials.

When patients have agreed to participate in a clinical trial, there is evidence that consent is not always as informed as it ought to be [58]. Many patients do not even recall that they are receiving experimental treatment [59]. This suggests that either the information was inadequate, given in an incomprehensible manner, or that patients' understanding was not checked sufficiently. In our analysis of doctor–patient interactions, despite protocol and ethical requirements exemplified in good clinical practice (CGP) guidelines, clinicians adopted somewhat idiosyncratic behaviours when providing information and eliciting consent to trials [5].

Particularly contentious is deciding just how much information needs to be given for consent to be informed [60]. Much has been written about patients' 'right to know', but less about patients' 'right not to know'. Several have questioned the ethics of overburdening patients with unwanted information. Logically, true autonomy should include patients' preferences for *less* as well as *more* information. Examination of taped recordings of consultations shows that when information about prognosis and the expected therapeutic benefits from the different trial treatment arms is withheld, this is usually an intuitive decision made by the doctor. It is rarely done as a result of enquiry into the patient's own stated preferences for information. A more rational basis for determining how much and what sort of information needs to be given to an individual patient who is eligible for entry into a clinical trial is required. Some efforts to do this have been made. For example, in one study 57 patients were randomised either to total disclosure of all possible relevant information or to an individual approach based on the doctors' intuition as to what patients wanted. The main findings suggested that total disclosure led to a better understanding of the research aspects of treatment and side-effects but less willingness to agree to randomised treatment and increased anxiety [61].

CAN BETTER COMMUNICATION SKILLS BE TAUGHT?

Medical and nurse education has undoubtedly produced many healthcare professionals working within oncology who possess excellent communication skills, but the system has failed the majority, to the detriment of both their own [36] and their patients' well-being [4].

Communication skills are critical to the practice of medicine and nursing but there is little consensus regarding criteria for adequate performance [62]. Insufficient attention has been paid to the development of standardised methodologies for the assessment of communication and the oncology consultation largely has remained outside the recent emphasis on quality of care and the resultant changes in delivery of cancer services. Members of oncology multidisciplinary teams rarely have systematically analysed their own communication skills or those of other team members and they are largely unaware of what might constitute ideal practice. Although as yet there are few rigorously evaluated clinical trials that demonstrate that interventions to improve communication skills result in improved health outcomes in cancer, there is evidence that effective communication can be taught, and that changes to skills are maintained and expanded [1, 63].

Methods to teach skills that produce demonstrable change use approaches incorporating cognitive, affective and behavioural components, and are learner-centred. For example, one such model, sponsored by the Cancer Research Campaign in the U.K., improved self-rated skills, increased the confidence of senior oncologists in key problem areas and improved their attitudes and willingness to teach communication skills to junior staff [1].

Communication within oncology can be stressful and challenging, but it also provides many opportunities for helping patients and their relatives understand more about, and receive, better care. Unless considerably more attention is paid to the training needs of healthcare professionals, improvements for patients are less likely to be achieved.

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