

# National Breast Cancer Centre

## Communication Skills Training Initiative



**NATIONAL BREAST  
CANCER CENTRE**  
Incorporating the  
Ovarian Cancer Program

### **An introduction to communication skills training: providing information to people with cancer**

The way a clinician communicates with a patient with cancer can have significant benefits for the person and their family. These benefits potentially include improvements in psychological adjustment, decision-making, treatment compliance and satisfaction with care.

People with cancer repeatedly report a desire to be well informed (Wiggers et al. 1990, Foot & Sanson-Fisher 1995). Effective communication, however, involves more than the provision of information; it requires a process of individually tailored explanation, problem solving and acknowledgment of the person's feelings. The main objective of the National Breast Cancer Centre's Communication Skills Training Initiative is to ensure that health professionals providing care for people with cancer have access to evidence-based communication skills training programs. However, prior to reviewing the evidence base for communication skills training, the psychosocial impact on people with cancer will be considered as it is a factor that influences the quality of clinician-patient communication.

### **The psychosocial impact of cancer**

People with cancer face many practical, emotional and psychological demands, in addition to their physical treatment. The evidence shows that these psychological needs are significant and frequently go undetected and unmet (National Breast Cancer Centre 2003). Irvine et al. (1991) conducted a comprehensive review of studies investigating the psychosocial impact of breast cancer on women. This review showed that twenty to thirty per cent of women experience some sort of disruption to their quality of life through factors such as loss of role, changes in their functional ability and/or problems with their social relationships.

While the symptoms associated with anxiety and depression can be common responses to a breast cancer diagnosis, clinically significant depression and anxiety

also prevail. A study of Australian women with early breast cancer found that up to forty five per cent had a psychiatric disorder; minor depression was detected amongst twenty seven per cent of the sample, and anxiety amongst less than ten per cent (Kissane et al. 1998). Anxiety levels have shown to increase at certain times, such as when discussing treatment options (Fallowfield et al. 1990). Research investigating the effects of anxiety on information processing suggests that anxiety may interfere with patients' ability to obtain and retain information they seek from physicians (Jepsen & Chaiken 1990).

There is evidence demonstrating the impact of depression on women with breast cancer. Depression has been found to be at least twice as common in women undergoing surgery for cancer as in women without cancer (Fallowfield et al 1990). Both disease progression and the diagnosis of a recurrence have been shown to be a very stressful time. In a study of patients with progressive cancer approximately forty per cent were found to be clinically depressed (Bukberg et al. 1984). Another study found that about half of the women diagnosed with a recurrence of breast cancer were experiencing a psychiatric disorder (Jenkins et al. 1991).

### **Providing psychological care for people with cancer**

Research evidence has shown that the psychological impact of cancer can be effectively managed through discussions with the treatment team and/or discussions with a psychologist or psychiatrist. Devine and Westlake (1995) conducted a meta-analysis of one hundred and sixteen studies that had investigated the impact of psychoeducational care on health outcomes for patients. This study showed that the opportunity to discuss feelings with a member of the treatment team or counsellor decreased emotional distress, such as body image concerns and depression. Benefits were also found with respect to reductions in anxiety, mood disturbance, nausea, vomiting, and pain.

An investigation of the impact of post-operative counselling on a group of mastectomy patients found that counselling enabled psychological distress to be recognised and patients with psychiatric problems to be referred (Maguire et al. 1983). This study reported a significantly lower level of psychiatric morbidity (twelve per cent) in the group that received counselling in comparison with the control group (thirty nine per cent).

Further information on the provision of psychological support and counselling is available in the Clinical practice guidelines for the psychosocial care of adults with cancer (National Breast Cancer Centre and National Cancer Control Initiative 2003).

### **The impact of poor communication**

Communication problems are often at the centre of poor clinician and patient interaction. Lerman et al. (1993) found that eighty four per cent of women with breast cancer had difficulties communicating with their health care providers. Over half of the women stated that their communication problems were a function of not being able to comprehend the information presented to them. Moreover, forty three per cent of these women found it difficult to ask questions or express their feelings.

The impact of poor communication on the well being of patients has been widely documented. Patients who believe that the information given to them at the time of diagnosis is inadequate do not adjust as well to their cancer and its treatment as patients who are satisfied with the manner in which the physician explains treatment options (Fallowfield et al. 1990). Furthermore Lerman et al. (1993) found that patients who reported communication problems were found to have increased anxiety, depression and anger at three months follow-up.

It has been shown that litigation against clinicians often results from patient dissatisfaction with communication. A study by Levinson et al. (1997) investigated the cause of malpractice claims made against primary physicians and surgeons and found a significant difference between the communication behaviours of physicians who had no claims against them and physicians with previous claims. The physicians with no claims had longer consultations, made more statements orienting the patient to the outcomes of the visit, and used more humour.

The poor communication skills exhibited by clinicians can be attributed to a perceived lack of the necessary skills (Sanson-Fisher et al. 1991). A survey of Australian surgeons' perceived competence in communication skills found that almost one third did not feel competent at increasing their patient's ability to remember, nor encouraging patients to express anxieties about their condition (Girgis 1997). Furthermore, it seems that medical training does not lead to an improvement in these skills (Perkins et al. 1998). Maguire et al. (1978) and Poole and Sanson-Fisher (1980) suggest that students' interactional skills are poorer after medical training than before.

The belief that communication skills will improve over time and be learnt through clinical experience and practice is not supported by the available research. Several studies have shown that the interpersonal skills of experienced clinicians are of a similarly poor quality to those of less experienced staff (Maguire 1985, Roter et al. 1990).

### **The impact of effective communication on patient and clinician outcomes**

Both patients and clinicians can benefit from improved communication. Effective communication not only improves patient understanding and trust during the clinical interview, but also increases compliance (Cockburn 1988, Hulka et al. 1976, Rolfe and Pearson 1994) satisfaction (Sanson-Fisher and Maguire 1980) and improves patient education and reactions to potentially distressing procedures (Rolfe and Pearson 1994).

A review of twenty one studies of physician patient communication found relationships between the quality of communication and several patient outcomes such as improved emotional health and a reduction in physical symptoms and pain (Stewart 1995). Another study investigating physical responses to improved communication found that blood pressure was reduced amongst patients who were allowed to express their health concerns without interruptions in the medical interview (Orth et al. 1987).

Hall et al. (1988) conducted a meta-analysis of forty-one studies investigating the effect of health professionals' behaviour on patient outcomes. This analysis showed that patient satisfaction was significantly associated with the provision of greater amounts of information. Furthermore, Maguire, Faulkner, Booth et al. (1996) found that the use of open-ended questions, questions with a psychological focus, empathic statements, and screening questions assisted patients in disclosing their concerns. Fogarty et al. (1999) investigated the impact of physician compassion on patient outcomes and found that simple empathic behaviours, which do not add much extra time to the consultation, can reduce patient anxiety levels.

It should be noted that clinicians can also benefit from improvements in their communication skills. Research has shown that effective communication skills can help manage stress and burnout in an oncological setting (Delvaux et al. 1988, Fallowfield 1995, Ramirez et al. 1996). In a study of three hundred and ninety three

British consultants, Ramirez et al. (1995) assessed the levels of emotional exhaustion, depersonalisation, and low personal accomplishment amongst clinicians. The findings estimated that twenty eight per cent of cancer clinicians had a psychiatric disorder, and found that clinicians that felt insufficiently trained in communication and management skills had significantly higher levels of distress than those who felt sufficiently trained did. This finding was supported by the work of Firth-Cozens (1987) who found that insufficient training in communication skills contributed to stress, lack of job satisfaction and burnout.

### **The effectiveness of communication skills training workshops**

There is considerable evidence to support the effectiveness of communication skills training on improving clinician confidence, self-awareness and a patient centred approach (Baile et al. 1999, Fallowfield et al. 1998, Gordon and Rost 1995, Lipkin et al. 1995, Maguire, Booth, Elliot et al. 1996). These studies have shown that basic interviewing and communication skills can be learned provided the training allows for:

- a problem based approach to learning
- key communication skills to be demonstrated by facilitators
- participants to practice the skills presented through role play scenarios
- the provision of feedback to participants through audio/videotape review
- the training to occur in small interactive groups, allowing multiple opportunities for practice and feedback

A review of communication skills training held through the American Academy on Physician and Patient (Gordon and Rost 1995) showed that participants improved in their interviewing skills, adopted a more learner centred approach and improved in their ability to self rate their behaviour and critique others. They concluded that effective communication skills can be taught, and when taught well, the changes are maintained (Gordon and Rost 1995).

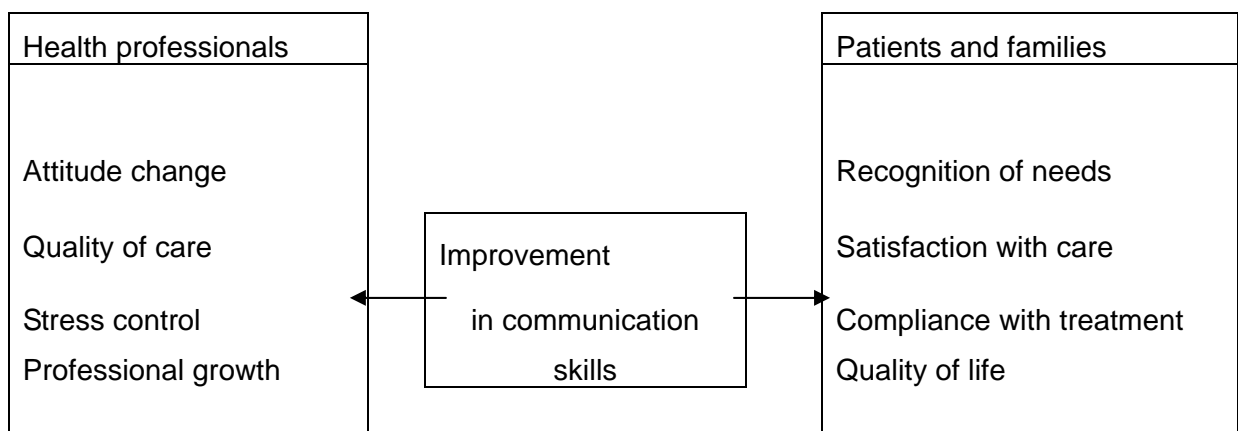
A study by Fallowfield et al. (1998) investigated one hundred and seventy eight senior clinicians who attended a one and a half or three-day residential course designed to enhance their communication skills development, knowledge acquisition and personal awareness. The main outcomes were self-rated confidence in key aspects of

communication, attitudinal shift towards a more patient centred interviewing approach. The research found that confidence ratings for key communication areas were significantly improved post-course, and at three months post-course ninety five per cent of the physicians reported significant changes in their practice of medicine. Clinicians showed positive changes in attitude towards patients' psychosocial needs and were more patient-centred in their approach.

A sample of thirty six medical students who had been provided with feedback on their interviewing skills during undergraduate training were assessed again four to six years later (Maguire et al. 1986). The students who had been given feedback during undergraduate training had maintained their superior interviewing skills. These skills included the ability to clarify the patient's needs, acknowledge and explore verbal and non-verbal cues given by the patient, and the use of precision in their communication practice. All these skills are associated with more accurate psychosocial and psychiatric diagnosis. This study concluded that communication skills can be taught, can be retained over time, and can be generalised to non-psychiatric patients (Maguire 1990).

Razavi and Delvaux (1997) have summarised the benefits of communication skills training in the following figure. It illustrates that improvement in communication can impact on both patient and health professional outcomes.

Figure 1 The potential impact of enhanced communication skills on patient and health professional outcomes (adapted from Razavi and Delvaux 1997).



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