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Communication skills training in oncology: a position paper based on a consensus meeting among European experts in 2009

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Background: Communication in cancer care has become a major topic of interest. Since there is evidence that ineffective communication affects both patients and oncology clinicians (physicians and nurses), so-called communication skills trainings (CSTs) have been developed over the last decade. While these trainings have been demonstrated to be effective, there is an important heterogeneity with regard to implementation and with regard to evidence of different aspects of CST.

Methods: In order to review and discuss the scientific literature on CST in oncology and to formulate recommendations, the Swiss Cancer League has organised a consensus meeting 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 and agreed upon.

Results: Recommendations address (i) the setting, objectives and participants of CST, (ii) its content and pedagogic tools, (iii) organisational aspects, (iv) outcome and (v) future directions and research.

Conclusion: This consensus meeting, on the basis of European expert opinions and a systematic review and meta-analysis, defines key elements for the current provision and future development and evaluation of CST in oncology.

Key words: breaking bad news, communications skills training, oncology, patient information

communication in oncology

Both patients and clinicians (both physicians and nurses) are affected by the quality of the exchange during consultations. Effective communication has been associated with improved psychological functioning of the patient [1, 2], adherence to treatment and pain control [3], enhanced information recall [1] and higher quality of life and satisfaction [1, 4]. Ineffective communication contributes to clinician's stress, lack of job satisfaction and emotional burnout [5] and results in patients' confusion [2, 6], increased psychological distress and difficulty in asking questions, expressing feelings and understanding information [2, 7].

While most people agree about the importance of patient-centred communication, especially in the field of oncology, substantial differences with regard to communication skills have been observed among oncology clinicians: for example, some clinicians utilise avoidance strategies, such as denial of patients' emotional suffering by focussing on medical information only; others respond empathically to the patients' cues and also discuss emotional and social aspects of disease [8]. In addition, it has been recognised that clinicians tend to use closed rather than open questions, that there are few exchange about psychosocial issues, that patients are not often given the opportunity to express their emotions and initiate discussions [1] and that patients often do not understand the phrases used in consultations and pick up only a small fraction of the provided information [9]. Consequently, over the last decade, there has been an increase in the development of so-called communication skills training (CST) programmes in order to correct these problems.

CST in oncology

CST is on the basis of assumptions that (i) effective communication requires specific skills, (ii) these are relevant for patients and clinicians and (iii) such skills can be improved by training [10, 11]. Effective communication skills are not just inborn qualities or a simple byproduct of the professional

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experience [7]; it has been shown that they can be modified and improved by specific training programmes [7, 10, 12–15] and (J. Barth and P. Lannen, unpublished data). Furthermore, it has been demonstrated that if effective methods are used, the new skills can be transferred into a clinical setting [13] and their impact is enduring [15, 16].

It has been repeatedly demonstrated that CST improves communication skills of oncology clinicians and systematic reviews and meta-analyses have confirmed these study results [10, 12, 17]. One systematic review on the efficacy of CST for health professionals was published in the Cochrane library [18]; on the basis of only three high-quality studies that focused on behaviour change (>40 studies with weaker designs were excluded from the literature search which ended in 2001), the author concluded that there is some evidence for the efficacy of CST. However, there is an important national heterogeneity with regard to implementation of such trainings and various aspects of evaluation, such as effectiveness of different pedagogic tools or of booster sessions, still need to be investigated. In addition, systematic reviews have also deplored a mismatch between stated behaviour and instruments or procedures used to assess them or the lack of reporting the theoretical frameworks [19].

With regard to the definitions and different models of CST, a considerable body of evidence provides a foundation for defining CST, determining their strategies and describing the different models of CST that can be taught [20–22]. Evidence indicates that the impact of CST is closely related to experiential learning through role-play sessions that rely on facilitators to guide learners. While the quality of CST trainers has only rarely been the focus of research, the literature indicates that modest training and minimal practice does not result in complete facilitator competence and that trainers' skills should be prioritised, thus allowing to evaluate the training of future CST facilitators [23].

consensus meeting on CST in oncology, Kappel am Albis, Switzerland, 2009

In order to review and discuss the scientific literature on CST in oncology and to formulate recommendations on the basis of existing evidence and expert opinions, the Swiss Cancer League (SCL) has organised the above mentioned consensus meeting in Kappel, Switzerland. A similar meeting was held 10 years ago, initiated by the SCL in 1998 in Ascona, Switzerland [22]. While this first meeting provided general recommendations with regard to the development and implementation of CST in oncology, the aim of this second meeting was to produce more detailed recommendations on the basis of increased body of research and accumulated experience with these training initiatives over the last 10 years.

programme and participants of the consensus meeting 2009

A systematic review and meta-analysis (J. Barth and P. Lannen, unpublished data) conducted by the Institute of Social and Preventive Medicine of the University of Bern, Switzerland, served to prepare the scientific evidence for some of the recommendations and to stimulate the discussion on yet unknown aspects of CST in oncology. During the first day, the review and meta-analysis were presented to the invited experts, opinion leaders and experts in the field of CST in oncology, researchers who have conducted level 1 studies (controlled trials) on CST, representatives of the European Society of Medical Oncology (ESMO), CST teachers and oncology clinicians who participated in such trainings. After the presentation of the literature, commented by an international expert (J. Bensing, L. Fallowfield, D. Razavi) and followed by a general discussion, five workshops addressed the following aspects of CST in oncology (i) setting, objectives and participants, (ii) content and pedagogic tools, (iii) organisation (implementation, quality management, teach the teachers and profile of CST teachers), (iv) outcome and (v) future directions and research.

Discussions in the workshop were on the basis of existing literature addressing specifically the five topics. Conclusions reached in these workshops were then presented and discussed in plenary sessions, followed by the elaboration of a consensus for recommendations.

On the second day of the meeting, representatives of patient organisations and of oncology societies were invited to join the meeting and the systematic review and recommendations were again presented and discussed in plenary and in two round tables.

recommendations

setting, objectives and participants

- CST is required at all the levels of professional education; in the postgraduate setting, CST should consist of a mandatory basic course and advanced courses on specific objectives such as discussing treatment options, end-of-life issues or identifying and treating psychosocial distress.
- At the moment, there is no evidence for the optimal length of CST in oncology with regard to effectiveness but there is some evidence for a dose–response relationship.
- A course of at least 3 days appears necessary to ensure transfer of skills into clinical practice.
- Supervision and periodic booster sessions are a promising add-on.
- Courses may be monodisciplinary or multidisciplinary according to the goal to be achieved.
- Courses should be given in small groups (4–6 persons per facilitator), which allows active participation and promotes interactivity.

content and pedagogic tools

- Learner-centred courses meeting individual and group needs must be run by trained and competent facilitators.
- Role play with structured/constructive feedback on communication skills is essential.

- Specific goals—relationship building, emotion handling, discussing complex information—may be achieved via group discussion, role play and/or didactic material including prepared videos with patients or actors.

organisation

- Trainers should be health care professionals with credibility and experience in an oncology setting.
- Trainers must have passed an accredited train-the-trainer course with assessment of key competencies, such as knowledge in establishing confidentiality rules and group safety, utilisation of a learner-centred approach, provision of opportunities for group to resolve problems, handling of conflicts and criticism, responding appropriately to comments made and individual reactions, meeting individual and group objectives, time keeping, self-awareness and experience in handling group dynamics.
- Participation in accredited CST programmes should be supported by professional societies and place of work and awarded Credits for Medical Education.
- Patient organisations should be encouraged to support the recommendations of the consensus meeting.
- CST must have financial support (unrestricted grants) from a variety of funding sources to ensure sustainability.

outcome

- Validated assessment measures should be used to permit consistency and comparability across studies.
- All outcomes, whether objective or subjective, must be tightly linked to course aims and content.
- Assessment of long-term impact is needed to evaluate maintenance of skills.

future directions and research

- Establishment of a European Institute for fostering CST and quality assurance of programmes and faculty.
- Future research:
- Use existing databases to further develop standardised, validated, reliable and responsive outcome measures.
- Investigate head-to-head comparison of existing interventions.
- Involve cancer patients in the definition of outcome measures.
- Evaluate different delivery methods of CST (for example, e-learning).

conclusions

While the first consensus meeting initiated by the SCL in 1998 (Ascona, Switzerland) provided only general recommendations with regard to development and implementation of CST in oncology, a rapidly growing body of evidence allowed the European experts involved in this second consensus meeting (Kappel, Switzerland) to formulate specific recommendations with regard to a variety of aspects of CST. We hope that this position paper invites other continents to review and potentially endorse the direction of these recommendations.

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