Purpose of review

Contemporary oncology practice acknowledges the importance of partnering with the patient and family in dealing with the illness. Patients also value their physicians as important sources of support when they provide information about the illness, encouragement, and hope, discuss treatment options, and address their concerns. For this reason outcomes associated with the quality of the physician-patient relationship have received increasing recognition. This review highlights relevant studies bearing on important outcomes of communication with the cancer patient and discusses the implication for training oncologists of the future.

Recent findings

Evidence is mounting that effective and empathic communication with the cancer patient and family can influence desirable outcomes in cancer care, which affect patient quality of life, satisfaction with care, and medical outcomes. Evidence also exists that communication and interpersonal skills can be taught and learned. Oncology training programs traditionally do not offer experience in this aspect of care although communication skills have now been defined as a core competency for oncology trainees. Finding motivated faculty to teach and providing time and structure in the curriculum are also major obstacles to be overcome.

Summary

Communication skills are the cornerstone of comprehensive cancer care. Learning this aspect of patient care can expand the supportive role of the oncologist especially at crucial times for the patient and family such as diagnosis, disease recurrence, and transition to palliative care.

Keywords

communication skills, information, oncology, physician-patient, support

Introduction

Patient communication has mistakenly been considered to be an innate skill of minor importance when compared with the technical aspects of care. Communication skills in reality are a key to achieving important goals of the clinical encounter in oncology [1]. These include establishing trust and rapport with the patient, gathering information, preventing psychological morbidity [2,3], addressing patient emotions [4], assisting patients in decisions about care, articulating an intelligible treatment plan, and enlisting the collaboration of the patient and family in treatment. The quality of the oncologist-patient communication has been shown to affect patient satisfaction with care [5], decision making [6], accrual to clinical trials [7], patient distress [8], and malpractice litigation [9,10]. Encouraging patients to ask questions, eliciting their options for care, and encouraging them to express opinions and state preferences result in measurably better health outcomes than when doctors do not engage in these behaviors [11,12]. Effective and supportive communication can assist the patient in navigating a successful transition to palliation and end-of-life care [13]. Moreover, the need for patient informed consent and the patient’s right to health care information and compassionate care create ethical, legal, and humanistic mandates for competent communication.

Measuring communication

The verbal and nonverbal exchanges that occur between physician and patient are understandably complex. Direct observations of clinical encounters have shed light on these interactions [14] but can be intrusive and introduce bias. Patient and physician recall can be unreliable. Recently, methods have been developed that allow us to open a window on this area. The most powerful of the new methods is the audiotaping or videotaping of the encounters, which allows the exchanges that occur in the clinical encounter to be closely examined. Several systematic methods for coding and scoring physician-patient dialogue in the oncology setting have been developed [15,16,17]. These have shed light on certain aspects of the dynamics of the clinical encounter, regarding such topics as information exchange, how clinicians may attempt to cushion bad news, the amount of time spent discussing patient concerns, and missed opportunities to make supportive statements to the patient. They have also been used to assess improvements in communication skills following training programs. Although more research groups are using these methods, the demonstration that...
observational findings can be translated into useful clinical recommendations that have an impact on patient care is still in an early stage.

Foundations and benefits of communication
The underpinnings of effective communication derive from theories and principles that translate into specific skills associated with the outcomes of care previously mentioned. Interpersonal psychology emphasizes respect for the patient, acknowledges the role of the clinician as healer, and promotes self-awareness of the role that our verbal and nonverbal behavior has on the patient [18,19*]. Legal and ethical principles mandate a patient’s rights to information about their illness and to participate in decision making about their care [20]. The psychology of the medical encounter addresses the interrelation between psychosocial and medical variables such as stage of disease, patient coping, compliance with treatment, and the impact that the patient’s suffering has on the physician’s behavior [21,22]. Each of these areas is associated with a set of skills associated with key outcomes of the physician–patient relation. For example, two recent papers that focused on empirical studies using coding of verbal and nonverbal behaviors during physician-patient interactions to identify specific but learnable skills that were associated with several important outcomes of communication in general medical practice [23,24]. These outcomes and examples of associated skills are summarized in Table 1.

Gaps in communication
Because of the threat posed by the cancer diagnosis, the uncertain outcome of treatment, and the physical and psychological hardships of cancer therapy, most patients require a high level of information about their disease [25] and substantial emotional support [26,27]. Even when they are motivated, patients often find it difficult to obtain timely information [28], and this may lead to patients being dissatisfied with the information they receive, misinformed about the status of their illness, or ignorant about the purpose of their treatment [29–32]. Patients often do not achieve their desires for participation in decision making [33] or understand the purpose of clinical trials [34]. Physicians miss opportunities to respond empathically to their concerns [35] and ignore patient wishes to discuss health-related quality-of-life issues [36]. Poor communication skills may be associated with the increased likelihood of receiving anticancer treatment at the end of life [37].

Table 1. Learnable communication skills associated with specific outcomes

<table>
<thead>
<tr>
<th>Communication skill</th>
<th>Clinical outcome</th>
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<tr>
<td>Friendliness, courtesy, empathy, being encouraged</td>
<td>Increases patient satisfaction</td>
</tr>
<tr>
<td>Listening, clarifying, summarizing</td>
<td>Enhances information exchange</td>
</tr>
<tr>
<td>Explaining, using humor</td>
<td>Increases compliance</td>
</tr>
<tr>
<td>Checking understanding, endorsing question-asking, offering</td>
<td>Facilitates shared decision making</td>
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Barriers to effective communication
The necessary time available for the oncologist to meet the information and supportive needs and expectations of the patient has decreased due to bureaucratic insurance and reimbursement issues [38]. Better oncology care has come at the price of more complex information for the patient to understand [39] and less time for the clinician to spend with the patient and family (Baile and Buckman, ‘On being an oncologist’ videocassette, Houston, TX: University of Texas, M D Anderson Cancer Center; 2002). Physicians struggle to provide accurate information and hope in the face of grave or uncertain prognosis [40,41*], and physicians may not understand the patient’s preferences or may disclose only partial information for fear upsetting the patient [40]. High-stakes interviews such as breaking bad news are stressful and require skills with which the oncologist may not be comfortable. Patients may be ambivalent about how much information they want (and therefore don’t ask) or use coping mechanisms that shun or minimize information [42]. Misunderstandings may result in a disconnect between physicians and patients, because physicians may feel it is up to the patient to bring up problems whereas patients may feel that if it is important the physician will bring it up [43]. In communicating with cancer patients, one of the most challenging tasks is responding to a patient’s emotions [44]. Physicians often miss opportunities to empathically respond to a patient’s feelings because they either fail to identify them or lack the knowledge of how to respond to them [35,45]. Although opportunities for postgraduate training are limited, education in this area is often enthusiastically received by participants [46]. Important global and geographical differences regarding ‘truth telling’ exist that reflect prevailing religious, social, and cultural norms aimed at ‘protecting’ the patient from the psychological impact of adverse information or determining that the family is the principal decision maker for care [47,48*,49]. An interesting study from Turkey, however, illustrates the fact that even in cultures where diagnostic cancer information is withheld, it increases the distress of patients, most of whom have already guessed their diagnosis from the treatments offered [50].

Giving bad news
Oncologists may give bad news thousands of times during the course of a career. This is especially true now that many patients are surviving longer. Giving bad news is a task that encompasses many basic communication skills such as
establishing rapport, providing accurate information to the patient, and addressing emotions. Breaking bad news is stressful for the clinician [51], and this may result in attempts to obfuscate or ‘cushion’ the bad news by avoiding discussion of important topics such as prognosis [14,52,53], falsely reassuring the patient that things will improve, offering treatment that will not further the goals of care, or burying discussions of prognosis in technical jargon. Physicians may use metaphors that frighten the patient, such as ‘I talked to the surgeon and he said he wouldn’t touch you with a ten foot pole …’ (personal communication from pancreatic cancer patient); destroy hope: ‘You have advanced cancer and there is nothing more we can do …’; or be excessively blunt: ‘Most patients with your disease are dead in 6 months.’ Patient reactions such as strong emotion, denial, or requests for a second opinion or difficult questions such as ‘How long do I have to live?’, may prove challenging for the physician to answer. There is little evidence that the difficulties in giving bad news get better over time.

Protocols for giving bad news can help by breaking the process into a series of steps [45,54••]. None of these have been studied empirically, even though they all represent to some extent best practices, in that they follow the recommendations of the literature and patient preferences [55–57].

Teaching and learning communication skills
Exposure to communication and interpersonal skills is often initiated in medical school but is rarely subsequently reinforced. Moreover, it is difficult to prepare the medical student for the clinical challenges that can occur in oncology practice. Physicians in oncology practice can readily identify their most important communication challenges [58]. These include giving bad news, dealing with strong patient and family emotions, transitioning the patient from curative to palliative care, and discussing end-of-life issues such as resuscitation. Few oncology training programs offer sufficient training in communication skills or support faculty development in this area [59,60]. One successful approach to teaching communication skills involves residential workshops of several days’ duration, where learners are intensively exposed to teaching using simulated patients using learning models based on adult learning theory, social psychology, and small group interactions [46,61,62]. Randomized clinical trials have demonstrated the efficacy of these programs. Fallowfield et al. [63] showed that oncologists attending a 3-day workshop were able to integrate skills into clinical practice. Razavi et al. [64] showed that basic workshops plus consolidation training were superior to workshops alone and facilitated the transfer of acquired skills into clinical practice. Recognizing that communication workshops are expensive and time consuming, several authors have addressed the issue of applying teaching techniques to the clinical setting [65,66]. Physicians in countries where a paternalistic approach has traditionally led to nondisclosure are now seeking to learn effective communication skills. Guidelines for shared decision making [67••] and obtaining informed consent [34] may be useful in guiding communication.

Empowering patients
Even though cancer patients in Western and many non-Western cultures desire much information about their illness, they often find it difficult to achieve timely and relevant access [68]. Access to the Internet has armed patients with a powerful information tool. It is estimated that on an average day, 5.5 million Americans look up health information on the Internet. The emergence of the Internet as a source of medical information has, however, afforded them more information about specific cancers [69–71]. A notable example is the use of the CHESS system by patients with breast cancer [69,72]. A recent American Society of Clinical Oncology survey underscored the benefits and challenges posed by patient Internet usage. Oncologists responding to the survey stated that 30% of their patients used the Internet to obtain cancer information [73]. Thirty percent of the 266 patients visited the Internet for cancer-related information and most brought information to their medical visit. Although it tended to prolong the length of the visit, many felt the information obtained provided hope to the patient, assisted them in finding new clinical trials, and increased their understanding of the illness. It can also represent a challenge to the oncologist-patient relation, however, when the doctor feels that a patient’s questions or challenges their advice and thus threaten the physician’s authority.

Several studies have been conducted to teach patients how to more effectively obtain the information they need in the oncology consultation. These involve preparing patients for their clinic visits using coaching techniques to increase their information-seeking behavior [74–76]. Although studies in this area are promising, the time expenditure and other barriers are unlikely to result in widespread adoption of this intervention. Other strategies that have proved useful include providing audiotapes of visits to patients [77] or providing feedback to the clinician about the patient’s concerns, and this has been effective in increasing communication [78].

Complementary and alternative medicine
In the United States, approximately 60% of cancer patients use some form of complementary cancer treatments. In Europe, the prevalence ranges from 14% in Greece to 75% among Italian patients [79]. Legal deregulation of the sale of medicinals, widespread but often unproven advertising of therapies, and the portrayal of nonprescription drugs as ‘natural’ compared with mainstream treatments have contributed to their widespread use among cancer patients. A recent survey of patients in a large cancer center in the United States [80] indicated that 83% of patients had used at least one complementary or alternative
approach, the most common of these being spiritual practices, followed by vitamins and herbs, then movement and physical therapies. This differs somewhat from practices in European and Asian countries, where more herbs and supplements are used. Complementary cancer therapies seem to serve an important role in patient coping. Patients report that they engage in complementary therapies to increase their hope or to enhance their sense of control by participation in their treatment. In some cases, the use of complementary cancer treatments may be a marker for increased patient distress or may be associated with a delay in seeking treatment. Few cancer patients use alternative treatments in lieu of conventional cancer treatment, however. Only a relatively small percentage of patients discuss use of these treatments with their oncologist, even though some therapies may interact unfavorably with cancer drugs. Patients may feel that it is not important or that their doctor is not interested. It is recommended, therefore, that oncologists routinely ask patients about their use of complementary and alternative medicines. An educational rather than a confrontational approach is recommended so as to acknowledge the patient’s initiative in contributing to a desire to improve their well being.

Conclusion
Various models and systems have recently been proposed to improve communication in cancer care. One suggested model is composed of seven stages of communication research, the goal of which is to provide a guiding structure for bringing coherence to oncology communication [81]. The stages in this model are: (1) identification of communication difficulties; (2) documentation of patient and clinician views; (3) identification of practices associated with better outcomes; (4) development of evidence-based guidelines and interventions; (5) testing of the effectiveness of the intervention in changing current practice and improving patient outcomes; (6) dissemination of the effective interventions; and (7) broad adoption of the intervention. Examples are provided for each stage of research to elucidate the type of study proposed topic. Recently a National Cancer Institute-funded initiative in communication research has resulted in the creation of four Centers of Excellence in Cancer Communication Research. It is unfortunate, however, that few of the studies proposed by these centers address communication in the clinical cancer setting.

References and recommended reading
Papers of particular interest, published within the annual period of review, have been highlighted as:
• of special interest
•• of outstanding interest
Patient-physician communication Baile and Aaron

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