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THE IMPORTANCE OF COMMUNICATION SKILLS TO EFFECTIVE CANCER CARE AND SUPPORT

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In the last decade there has been an increasing emphasis on the teaching of communication skills. Why is this now considered so important, and does communication really influence patient outcomes in cancer care? The rationale for communication skills training in cancer care comes from a number of related points:

- good communication is a basic component of good clinical care, without which even the technical aspects of medicine cannot be effectively delivered;
- cancer carries with it a high psychological burden, thus the costs of poor communication are particularly salient in this patient population;
- the literature suggests there are currently substantial problems in doctor–patient communication;
- there is clear evidence that effective communication can make a difference to patient outcomes such as understanding and psychological adjustment;
- cancer patients place good communication high on their priorities for care;
- doctors regard their current training as inadequate, and cite communication difficulties as a major contributor to stress and burn-out;
- research has proven that communication skills can be taught and maintained.

This article presents the rationale for training in communication skills to be a priority for teams caring for cancer patients.

Kurtz, Silverman and Draper, in their text on teaching communication skills in medicine, state strongly that ‘communication skills are not an optional extra in medical training; without appropriate communication skills, all our other clinical efforts can easily be wasted’.¹ It has been estimated that doctors engage in 200,000 consultations in a professional lifetime, during which diagnoses are made, treatments are discussed, health care is delivered and patients’ needs are assessed and met. Furthermore, numerous other interactions between

members of the health team and patients involve communication at their core. The communication tasks in such interactions typically involve the gathering and delivery of information, and the provision of emotional support. Arguably, cancer patients have a particularly strong need for good communication in these domains.

Surveys of cancer patients show an increasing desire over time, especially among younger patients, to know everything about their cancer, and to be involved in making treatment decisions.^{2–5} For example, over 90 per cent of patients in Lobb et al.’s study of patients with early stage breast cancer wanted to know their chance of being cured and the staging details of their cancer.² In another Australian study,⁶ over 60 per cent of cancer patients seeing an oncologist for the first time indicated a preference for making a treatment decision either in collaboration with their doctor or on their own. Medical ethics has shifted from a paternalistic stance to one emphasising patient autonomy, with informed consent seen as the gold standard for achieving this end. However, informed consent requires much from both parties. Doctors are required to impart complex and potentially threatening information in a manner tailored to patient needs, provide a clear recommendation, and encourage a collaborative framework of decision-making. Such skills are not easily developed.

While a high standard of communication is often evidenced in cancer care, the literature suggests gaps and areas of particular difficulty. For example, while patients often report high satisfaction with overall care, Wiggers et al. reported much lower satisfaction (20–30 per cent) on items dealing with specific content areas and patient control.⁷ Patients were very dissatisfied with information about treatment benefits, side effects and symptom control, and about achieving a sense of control over their life. Complaints about the amount of information provided, the manner in which it is given, and its comprehensibility, were also commonly reported in a recent audit of hospital services in England.⁸ Indeed, the majority of malpractice allegations arise from a communication breakdown.⁹

Cancer patients also have high emotional needs. Prevalence rates for depression are reported as between

47 per cent and 58 per cent,^{10,11} in comparison to a 5.8 per cent prevalence rate of depression in the general population, estimated in the general United States population.¹² Despite being common, psychological problems such as depression are still under-detected and under-treated in oncology practice.¹³ Early studies found that only 15 per cent of patients who merited psychiatric intervention were referred as part of usual care, and that even after a psychiatric liaison service was established, around 50 per cent of patients with major affective disorder were not referred by clinical oncology staff.¹⁴

Many studies have reported the difficulties medical practitioners face in detecting psychological concerns and addressing emotional issues with patients. For example, an Australian study used a standardised questionnaire to measure patients' levels of anxiety and depression before a consultation, and compared these with oncologists' perceptions. Most oncologists were unable to predict their patients' psychological status to a degree that was better than chance.¹⁵ In another study,¹⁶ 298 patients with heterogeneous cancers had their initial consultation with one of nine oncologists audio-taped. Transcripts of the audio-taped consultations were analysed and cue frequency, cue type (informational or emotional), and doctor responses (responded to or not responded to) were recorded. Patients gave a median of two cues per consultation, of which about 30 per cent were for emotional support. Oncologists responded appropriately to only about 28 per cent of these cues, with some oncologists systematically responding to more cues than others. Interestingly, the consultations of those oncologists who responded to most information cues were significantly shorter than those of oncologists who responded to fewer cues.

There is now a large literature showing that patients who are satisfied with doctor–patient communication:

- understand more about their illness and complex combinations of treatments and drugs that are used;
- are more compliant—that is, are more likely to follow instructions and follow treatment plans;
- demonstrate better psychological adjustment—that is, are less anxious and depressed;
- are generally more satisfied with their care and with the physician.^{17–20}

For example, an English study found a significant positive impact on patient well-being—even a year after diagnosis—of seeing a doctor who encouraged patient participation in decision-making.¹⁹

Doctors, too, appear to benefit from communicating well. There is evidence that doctors who are anxious and lack confidence in responding to patients' emotional needs are those who are at most risk of 'burnout'.²¹

The variability of practitioners' current practices, the potential of the consultation process to adversely affect both providers of care and patients, and the strong evidence

for better outcomes with better communication, suggests that communication skills training should be a priority for cancer teams. This has been recognised, not only by patient advocate groups who have called for further training for doctors in management of psychosocial aspects of cancer care,²² but also by the clinicians themselves who have indicated interest in participating if appropriate programs were available.²³

An evidence-base for effective communication practices within the treatment team is now available, at least in some areas. Randomised controlled trials and meta-analyses have been conducted showing the effectiveness of these interventions for improving well-being, reducing psychological distress, and effectively managing major effective disorders among cancer patients.^{24,25} The recently released National Health and Medical Research Council psychosocial clinical practice guidelines have been developed to assist members of the treatment team to provide evidence-based supportive care to meet the various psychosocial needs expressed by their patients.²⁶ The majority of the recommendations reflect changes in the clinician–patient interaction, but advice is also given about appropriate circumstances for referral for group support, counselling, psychiatric and/or other interventions.

While the literature in this area is comparatively small, there is evidence that training programs in communication skills can make a difference both to doctor behaviour and patient outcomes. Such programs have been reported to lead to doctors using more of the targeted consultation skills in assessments with simulated patients, to increase clinicians' confidence in communicating effectively with patients and to enhance clinicians' positive attitudes towards patients' psychosocial needs.^{27,28} The effect on patient outcomes has not been studied extensively, because of the complexities and size of the studies required. However, one small study from the United States found that 18 patients of specialist oncologists who had been randomised to a communication skills workshop, reported feeling less depressed and more in control than the 18 patients of doctors in the control group.²⁹

In conclusion, there is a strong theoretical rationale and considerable data supporting the importance of effective communication in cancer care. Training programs in key areas identified as problematical by clinicians and patients (such as breaking bad news, discussing prognosis, presenting treatment options, and obtaining consent to clinical trials) are currently available through a number of sources.

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PSYCHOSOCIAL GUIDELINES IN CANCER CARE AND SUPPORT

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The increasing demands of consumers for attention to the psychosocial aspects of care has been acknowledged with the release of clinical practice guidelines for the psychosocial care of women with breast cancer. This article describes the development of the *Psychosocial Clinical Practice Guidelines: information, support and counselling for women with breast cancer* by the National Breast Cancer Centre, which have been endorsed by the National Health and Medical Research Council.¹ These Guidelines provide a valuable model for the promotion of psychosocial care for all patients with cancer.

BACKGROUND TO THE DEVELOPMENT OF THE GUIDELINES

Approximately 10,000 Australian women are diagnosed with breast cancer every year. In addition to the demands of their physical treatment, these women must contend with complex practical, emotional, and psychological demands. Between 20–30 per cent of women with breast cancer experience a reduction in their quality of life due to emotional distress and a disruption of their roles;² however, emotional support and access to appropriate information remain major unmet needs of Australian cancer patients.³ The depth of community feeling about the emotional effects of breast cancer entered the public