Breast cancer: communication with a breast cancer patient and a relative

I. Merckaert1, Y. Libert1,2,3, N. Delvaux4 & D. Razavi1,3

1Université Libre de Bruxelles, Brussels; 2C.A.M. (Training and Research Group), Brussels; 3Institut Jules Bordet, Brussels; 4Hôpital Erasme, Brussels, Belgium

Introduction

Communication is now recognised as a core clinical skill in medicine in general and in cancer care in particular. Communication in cancer care is particularly challenging due to fear and stigma associated with cancer, complexity of medical information and uncertainty about the course of the disease [1]. Physicians in their every day practice have to deal with breaking bad news, informing patients about highly complex treatment procedures, asking for informed consent, and dealing with anxious and depressed patients and relatives. New models for cancer care have moreover placed the responsibility of identifying patients’ needs with the oncologist [2]. Theoretically, to promote patient decision-making, recall of information and satisfaction, health-care professionals need to adapt information to every patient’s needs. To do so, they have to take into account contextual, cognitive and emotional barriers. Health-care professionals in cancer care thus face highly complex communication tasks for which they generally have received only little training. Effective communication skills are important as they have an influence on patients’ outcomes. A recent review concluded that effective communication improves patients’ health by positively influencing emotional health, symptom resolution, functioning and pain control [3]. Communication is also related to patients’ psychological adjustment to cancer [4–9], recall of information provided, adherence and satisfaction [10]. In the last few years, research has also indicated the importance of including relatives in the care of cancer patients. In the case of breast cancer, there is a growing literature suggesting the need to view women who have cancer and their spouse as a unit [11]. However, little research has focused on physician communication skills training in the context of three-person interviews.

The place of patients’ relatives in cancer care

Around one-fifth of medical interviews in cancer care imply the presence of a relative [12]. Results of a recent, not yet published, study conducted in Belgium including 129 breast cancer patients showed that half of them were accompanied by a relative and one-third by their spouse [13]. Relatives are directly involved in obtaining information, in decision-making and in the everyday care of the patient [14]. Accompanying relatives are predominantly spouses, followed indeterminately by children, parents or siblings [12, 15, 16]. Results of previous studies indicate that relatives are often present in ‘difficult’ situations or when patients are ‘vulnerable’ [12, 15, 16]. Relatives are more likely to be present when the patient is older and has a poorer performance status. Relatives are also more likely to be present at specific time points in the course of the disease: for initial visits, immediately after cancer recurrence and in the terminal phase of the disease rather than in a routine follow-up visit. They mainly accompany the patient to provide support or to serve as the patient’s advocate. Accompanying relatives moreover are also frequently patients’ primary caregivers.

As patients’ caregivers, relatives could be reliable witnesses of patients’ difficulties in coping with cancer [17–20]. Therefore, asking them to express their perception of patients’ physical symptoms, distress and concerns could help physicians to inform and support their patients more appropriately. Moreover, the increase in outpatient care and the shortening of hospital stay associated with the increase in cancer patients’ life expectancy have led many relatives of cancer patients to face an increasing amount of emotional as well as practical tasks [21]. Those tasks are often complex and highly burdensome, and can result in heightened distress levels among relatives. Research results indeed suggest that family members of cancer patients show signs of depression and anxiety, and experience restriction of roles and of activities, strain in marital relationships and diminished physical health [22]. Between 10% and 30% of relatives probably suffer from psychiatric morbidity, a level that is likely to increase as the illness advances and treatment becomes palliative [21]. Finally, it is important to note that caregivers’ bad adjustment has been associated with patients’ poor social rehabilitation [23], poor treatment adherence [24] and increased emotional distress [25, 26]. Physicians’ communication skills in addressing relatives could thus improve patients’ support and quality of life, as they could improve this adjustment.

Physicians’ communication skills in three-person interviews

Despite the importance of the accompanying relative in the context of cancer care, little is known about physicians’
communication skills in a three-person interview. One study comparing initial visits in primary care reported that neither the content nor the quality of physicians’ interactions was affected by the presence of a relative. Patients’ behaviours, however, were different: compared with two-person interviews, elderly patients in three-person interviews raised fewer issues, were less responsive, less assertive and less expressive [27]. Only one study in cancer care compared physicians’ interactions when a patient was alone and when a patient was accompanied by a relative. This study showed that when a relative was present interactions were slightly longer (3 min) and that physicians were likely to provide more information [16]. Overall, physicians seem to be able to only slightly adjust their communication for the presence of a third person. The relative seems either to take the patient’s place in the interview or to remain somewhat unacknowledged. Ideally, physicians should be able to use effective communication skills allowing them to assess [28, 29], to inform [30] and to support [31] both patients and their relatives adequately. Although several studies have reported the usefulness of communication skills training programs for physicians working in cancer care [32–39], no study had specifically assessed their usefulness on physicians’ communication skills when a patient is accompanied by a relative.

Impact of communication skills training programs

One recent study aimed to assess the efficacy of six 3-h consolidation workshops conducted after a 2.5-day basic training program on physicians’ communication skills in three-person interviews [40]. Physicians, after attending the basic training program, were randomly assigned to consolidation workshops or to a waiting list. Training efficacy was assessed through simulated and actual interviews that were recorded on an audiocassette and after consolidation workshops for the consolidation-workshops group, and 5 months after the end of basic training for the waiting-list group. Communication skills were assessed according to the Cancer Research Campaign Workshop Evaluation Manual. Patients’ and relatives’ perceptions of and satisfaction with physicians’ communication performance were assessed using a 15-item questionnaire. Studying three-person interviews requires analysing separately the physician’s communication skills when addressing each participant in the interaction individually and both of them simultaneously. The primary end point was to assess the benefits of consolidation workshops in terms of communication skills of physicians when they address the patient, the relative and both at the same time. The secondary end points were physicians’, patients’ and relatives’ perception of and satisfaction with physicians’ performance.

Sixty-three physicians completed the training program. At baseline, physicians directed 66% of their utterances to patients, 13% to relatives and 13% to both patients and relatives. No change was observed in this regard following training. Compared with physicians who participated in the basic training program, physicians who were randomised to the consolidation workshops used more open, open directive and screening questions when they addressed the patient, and more often elicited and clarified psychological concerns. When they addressed the relative, physicians who were randomised to the consolidation workshops gave less premature information in simulated and in actual patient interviews. When they addressed the patient and the relative simultaneously, physicians who were randomised to the consolidation workshops used more empathy, educated guessing, alerting to reality, confronting, negotiating and summarising. This was observed in both simulated and actual patient interviews. Patients, but not relatives, who interacted with physicians who were randomised to the consolidation workshops were more globally satisfied with the interviews.

In three-person interviews, post-consolidation workshop communication skills changes reflected a greater openness towards patients’ and relatives’ concerns and needs. This was observed in both simulated and actual patient interviews. The results of this study show a transfer of skills acquisition to clinical practice. The results also underline that changes towards relatives are more modest in actual interviews than in simulated interviews.

Finally, patients who interacted with physicians who were randomised to the consolidation workshops reported higher scores concerning their perception of physicians’ assessment of their concerns and a higher degree of satisfaction with physicians’ performance. It should be emphasised, however, that the higher degree of satisfaction with physicians’ performance was not found for relatives. This may be related to the modest changes that were observed in physicians’ use of communication skills when they addressed relatives.

To summarise our results, it may be concluded that six 3-h bimonthly consolidation workshops following a 2.5-day basic training improved communication skills in addressing patients and relatives. A basic training program consolidated by workshops is certainly a way of promoting more efficient physician—patient—relative communication. This study shows that the transfer of skills in addressing relatives’ concerns and needs remains limited.

Conclusions

Physicians should be aware that communicating with a patient and a relative requires skills. The specificity of three-person interviews, so frequent in cancer care, should be recognised (patients’ and relatives’ respective agenda, adequate interview duration and specific communication skills). The practice of three-person interviews should ideally start during medical school and should be consolidated further by specific training modules targeting barriers to addressing relatives. Transfer may be facilitated by asking physicians to choose to practice specific skills related to the core elements of a three-person medical interview in between training sessions. Finally, the need to devote more consultation time for three-person interviews should be recognised in order to allow physicians to address the relatives’ concerns and needs.
The results of this study, showing that transfer may be more limited as far as relatives are concerned compared with patients, emphasise the need to focus systematically some consolidation workshops on the practice of three-person interviews. Despite the fact that consolidation workshops following a basic training program are both time and resource intensive, they are probably necessary in order to facilitate the transfer of newly acquired communication skills when addressing not only patients, but also relatives.

There are four lessons to take away. First, communicating with a patient and a relative requires a motivation to include the relative in the process of care. Secondly, the inclusion of the relative requires the acquisition of specific skills. Thirdly, the acquisition of these skills requires appropriate training. Fourthly, the use of these skills would probably be facilitated by devoting longer consultation time for a three-person interview.

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