COMSKIL Communication Training in Oncology—Adaptation to German Cancer Care Settings

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Abstract

Medical communication is a skill which can be learned and taught and which can substantially improve treatment outcomes, especially if patients' communication preferences are taken into account. Here, we give an overview of communication training research and outline the COMSKIL program as a state-of-the-art communication skills training in oncology. COMSKIL has a solid theoretical foundation and teaches core elements of medical communication in up to ten fully operationalized modules. These address typical situations ranging from breaking bad news to responding to difficult emotions, shared decision-making, and communicating via interpreters.

Keywords

Neoplasms · Communication · Medical psychology · Physician-patient relations · Continuing medical education

1 Background

Identifying patients' communication needs and preferences represent a complex and challenging task for doctors and other members of the multidisciplinary team; it requires high cognitive and communication skills. Accurate perception of patients' needs is crucial for effective doctor–patient communication. Such needs include not only

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U. Goerling and A. Mehnert (eds.), *Psycho-Oncology*, Recent Results in Cancer Research 210, https://doi.org/10.1007/978-3-319-64310-6_12

preferences and expectations regarding medical issues but also general interpersonal needs (Hack et al. 2005). A trusting relationship can influence important outcome parameters of medical treatment as well as psychosocial distress, the ability to cope with the illness and treatment adherence (Fallowfield and Jenkins 1999; Watson et al. 2005). Therefore, interventions which improve medical communication also bear the potential of improving cancer treatment outcomes (Butow et al. 1999).

Evidence from medical psychology research suggests that doctor–patient communication is a skill which can be learned and taught effectively by well-structured communication training programs (Barth and Lannen 2011). Nonetheless, there are very few programs which include patients' communication preferences as a central element. One of these programs is COMSKIL, which was developed at Memorial Sloan-Kettering Cancer Center (MSKCC) in New York (Brown and Bylund 2008; Bylund et al. 2010; Kissane et al. 2012). Here we will give an overview of communication training research and outline the COMSKIL program as a state-of-the-art communication skills training. It provides a core curriculum for oncology training programs (Kissane et al. 2017) and creates a glossary of communication skills, which empower the clinician to constructively reflect on their communication and improve whenever needed.

2 State of the Research

Numerous psycho-oncological studies have found that a substantial proportion of cancer patients show psychosocial distress in need of treatment, which is not recognized or treated adequately in clinical practice (Mallinger et al. 2005; Mehnert et al. 2014; Mitchell et al. 2011). In light of these findings, optimal doctor–patient communication represents the corner stone of patient information, provision, support and compassionate care, thus improving treatment adherence and thereby successful treatment (Fallowfield and Jenkins 1999; Maguire 2002; Rehse and Pukrop 2003; Thorne et al. 2008). Particularly, difficult conversations include breaking the bad news about the diagnosis, informing patients about invasive treatment, cancer recurrence or the transfer to palliative treatment. Doctors experience such consultations as highly distressing (Brown and Bylund 2010; Fallowfield and Jenkins 2004; Parker et al. 2010).

There are many reasons for enhancing clinicians' communication skills. It is not only patients who criticize doctors' communication behavior, but also physicians who have emphasized a need for improvement (Back et al. 2005; Brown et al. 2007; Butow et al. 2004; Mallinger et al. 2005; Parker et al. 2010). In reaction, a variety of expert recommendations have been drafted (Baile et al. 2000; Epstein and Street Jr. 2007; Holland and Alici 2010; Lee and Wu 2002; Okamura et al. 1998), which were the basis for a wide range of communication trainings from individual lectures to programs for continued medical education which last several days (Barth and Lannen 2011; Butler et al. 2005; Cegala and Lenzmeier Broz 2002; Rao et al. 2007; Uitterhoeve et al. 2010). A general difficulty of such interventions is that a clear conceptualization of communication skills

Table 1 Overview of commuinication training programs

Region	Program	Topics	Target audience	Teaching structure	Duration	Outcome parameters
New York (USA)	COMSKIL (implemented at MSKKC since 2005)	Conceptual introduction, communicating bad news, discussing the prognosis, dealing with anger, conversation with patients and significant others, communication via translator, shared decision making, obtaining informed consent for clinical studies	Doctors, nurses	Short lectures, role play with actors, video analyses, feedback, small groups (6 participants)	2 days	Self-report regarding skills and satisfaction, video analyses
Texas (USA)	Oncotalk (developed in 2002)	Communicating with palliative care patients	Doctors during residency	Short lectures, role play with actors, feedback, small groups (5 participants)	3.5 days	Self-report regarding skills and satisfaction, audio analyses
Switzerland	Communication training program (introduced as obligatory by the Swiss Society for Medical Oncology in 2001)	4 elements of communication: structure, exchange of information, emotion, relationship aspects	Doctors during oncological residency, nurses	Case discussions, role play with actors, audio recordings (pre/post), small groups (10 participants)	2 days, 4-6 single supervisions, half-day workshop	Self-report regarding skills and satisfaction, audio analyses by blinded raters
Australia	Several programs, traditionally a small workshop model for one specific topic	E.g., basic communication skills, breaking bad news, improving communication in an interdisciplinary team	All oncological health care professionals	Short lectures, role play with actors, small groups (4–6 participants)	3–4 h	Self-report regarding skills and satisfaction
Great Britain	Postgraduate course for palliative care specialists at Cardiff University	Internet-based portfolio e-learning system and communication trainings with different content	All oncological health care professionals	E.g., short lectures, role play with actors, video analyses, supervision, visitations with colleagues	2 years	N/A

(continued)

Table 1 (continued)

Region	Program	Topics	Target audience	Teaching structure	Duration	Outcome parameters
Brussels (Belgium)	Training programs of varying scope	Basics of communication, dealing with patients' anxiety and distress, identifying distressed patients, discussing the prognosis, dealing with death and dying	Nurses, social workers, work therapists	Lectures, role play with actors, audio recordings (including real patients), small groups (12 participants)	12 h 1 day 2.5 days 105 h	Self-report regarding skills and satisfaction, audio analyses, patient satisfaction and quality of life
	Basic communication and consolidation work shop	Aims, purpose and specifics of communication, dealing with patient distress, conversations where significant others are present	Doctors	Lectures, actor patients, video recordings (incl. real doctor–patient consultations), role play, small groups (6 participants)	40 h 3 h	Self-report regarding skills and satisfaction, distress, video analyses, patient satisfaction and quality of life
Germany	Kompass (compact course plus consolidation work shop)	Breaking bad news, shared decision making, transition from curative to palliative care, support in dealing with the disease, conversations about death, dying, ethical problems	Doctors	Lectures, patient actors, video recordings, role play, small groups (10 participants)	2.5 days 1 day	Self-report regarding skills and satisfaction, distress, video analyses
	COM-ON-p or COM-ON-rct	Transition from curative to palliative care or information about randomized controlled trials (RCT)	Doctors	Lectures, role play with patient actors, video recordings, small groups (8-9 participants)	1.5 days	Self-report regarding skills and satisfaction, video analyses

has been lacking. Therefore, outcome variables for operationalization and efficacy studies have not been defined well (Cegala and Lenzmeier Broz 2002). These methodological limitations are also evident in the majority of studies evaluating training programs (Barth and Lannen 2011; Fellowes et al. 2004; Gysels et al. 2004, 2005). These reviews conclude that the best results are achieved by those programs that comprise a combination of different learner-centered methods and a mixture of theoretical and practical elements. Table 1 shows an overview of international initiatives to improve medical communication skills.

Complex training programs have been able to improve communication skills, although these changes have been mostly assessed by subjective self-report (Barth and Lannen 2011; Bylund et al. 2010; Delvaux et al. 2005; Fallowfield et al. 2002, 2003; Jenkins and Fallowfield 2002; Lenzi et al. 2011; Merckaert et al. 2005; Razavi et al. 2003). With regard to patient-related outcome parameters, studies have found an increase in patient satisfaction and trained doctors have shown greater awareness of patients' psychosocial issues (Delvaux et al. 2005; Merckaert et al. 2005; Uitterhoeve et al. 2010; Visser and Wysmans 2010). Evidence for improved mental health reduced patient distress or enhanced coping skills has been scarce (Barth and Lannen 2011; Uitterhoeve et al. 2010). Furthermore, although training programs aim to consider individual patient needs, the immense variety and diversity of such issues have made the development of a comprehensive curriculum challenging (Dale et al. 2004; Echlin and Rees 2002; Girgis et al. 1999; Mallinger et al. 2006). In their review of the literature, Kiesler and Auerbach found that

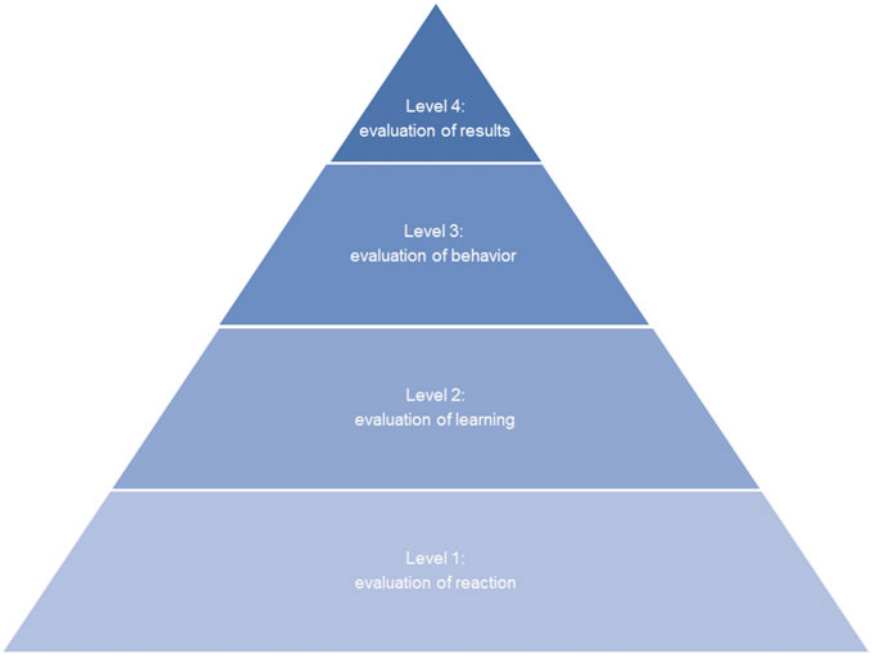

Fig. 1 Kirkpatrick's Triangle showing levels of assessment for communication training programs; adapted from Hutchinson (1999)

successful communication between doctor and patient depends little on accordance with recommendations and guidelines; it is rather the result of congruence between the patient's needs and the doctor's response (Kiesler and Auerbach 2006). This emphasizes the need for training programs which teach how to identify changing communication needs throughout the trajectory of care.

Common outcome criteria in this field are: patient satisfaction with doctors' communication, patient competence and knowledge of their illness, and doctors' empathy as perceived by the patient, consideration of patients' communication preferences during the consultation, doctor satisfaction with the training, improvements in communication skills, doctors' feeling of being overwhelmed, and change of communication behavior (Barth and Lannen 2011).

One of the most widely used assessment models for training programs Kirkpatrick's Triangle, (Kirkpatrick 1967; Konopasek et al. 2010). It consists of four levels of evaluation (Fig. 1) to assess the impact of a training program. The first level focuses on immediate reactions to the training, offering an opportunity for trainees to voice their opinions, self-efficacy, and level of satisfaction with the training. The second level assesses new knowledge and skills in a standardized way. The third level measures changes in actual behavior in the clinical setting when communicating with real rather than simulated patients. At the fourth and highest level, the overall impact in terms of benefits to patients and other members of the care system is assessed. The COMSKIL Coding System is one way to assess and code the use of communication skills and strategies taught during the program(Bylund et al. 2008).

3 COMSKIL: Theoretical Foundations and Structure

The COMSKIL communication training was developed at Memorial Sloan-Kettering Cancer Center (MSKCC), New York, USA in 2005 (Banerjee et al. 2015; Brown and Bylund 2008; Bylund et al. 2010; Kissane et al. 2012). It is a multidisciplinary curriculum, which applies not only to doctors but also to nurses and other members of the health care team. It aims to overcome many of the methodological limitations of other programs and studies by teaching the core elements of doctor–patient communication in a thoroughly operationalized way and with a solid theoretical foundation (Brown et al. 2009). COMSKIL was developed from three theoretical models: goals, plans, and action (GPA) theories (Berger 1997), sociolinguistic theory (Miller 2007) and Leventhal's common sense model (Donovan and Ward 2001). Based on the premise that goals and plans guide communication, GPA theorists have ordered components of interpersonal communication in a hierarchy from goals, the most abstract component, via plans to actions, the most concrete element (Berger 1997). This goal-centered approach is combined with a communication style, which sociolinguistic theory describes as person-centered communication. In this model, the practitioner acknowledges that there is more than one way to reach a given communication goal and is able to adapt their communication in response to the perspectives, feelings, and intentions of others (Miller 2007). A third aspect stems from

the view that illness is understood through common sense. Patients may develop a comprehensive concept of an illness by incorporating information provided by the physician and thereby questioning and deepening their common sense concept. Patients' representations of illness and treatment are thus continually modified, cross-checked and updated in a process that becomes self-regulating (McAndrew et al. 2008). It is the clinician's responsibility to understand and review the patient's explanatory model and guide the patient's understanding toward the clinician's medical model. By incorporating these theoretical constructs, COMSKIL aimed to increase the practitioner's flexibility and to expand the range of their communication skills such that they can consciously apply a skill as the situation requires it.

COMSKIL has five core components which will be explained in turn: goals, strategies, skills, process tasks, and cognitive appraisal (Fig. 2). A communication goal is a desired state that the individual is trying to attain. The other core elements serve to achieve such communication goals. Thus, to reach a shared treatment decision, the communication goal is "to help the patient make a fully informed treatment choice, based on a detailed understanding of their illness, the benefit and burden of each treatment option, and its impact on their lifestyle and values, so that their choice optimally suits the patient."

Communication strategies are more concrete than goals and are defined as plans which direct behavior toward the realization of a goal. Using several strategies in the sequence may serve to realize different aspects of a goal, e.g., an emotional and an information-related aspect. The order of execution of these strategies can be varied to meet individual needs and achieve patient-centered communication. Table 2 illustrates these strategies in specific modules of the curriculum.

Communication skills are the most concrete elements and are defined as discrete units of speech which can further the clinical dialog. Skills are concrete, teachable, and observable. They contain elements such as checking a patient's understanding of the information conveyed, validating a patients' feelings or explaining and

Fig. 2 Core components of COMSKIL modules. Communication goals are achieved through a series of sequenced strategies, which in turn are accomplished via skills and process tasks. Cues from the patient produce cognitive appraisals in the clinician, whereas barriers block open communication and can arise in either party; adapted from Kissane et al. (2012)

Table 2 COMSKIL modules and main strategies

Module	Strategies
Breaking bad news	1. Establish consultation framework 2. Tailor the consultation to the patient's needs 3. Provide information in a way that it will be understood and recalled 4. Respond empathically to emotion 5. Check readiness to discuss management options 6. Close the consultation
Discuss prognosis and risk	1. Ascertain the patient's need for prognostic information 2. Negotiate the type and format of prognostic information 3. Provide information in a manner that is sensitive to the patient's needs and promotes hopefulness 4. Respond emphatically to emotion 5. Respond to patient information cues
Shared decision making	1. Establish the consultation framework 2. Establish the physician–patient team 3. Develop an accurate, shared understanding of the patient's situation 4. Present established treatment options 5. Discuss the patient's values and lifestyle factors that may impact on the standard treatment decision 6. Present a clear statement of the recommended treatment option and invite patient choice 7. Close the consultation
Responding to difficult emotions	1. Allow the patient to recount concerns or grievances 2. Work toward a shared understanding of the patient's emotional experience 3. Empathically respond to the emotion/experience 4. Explore attitudes and expectations leading to the difficult emotion 5. Facilitate coping and connect to social support
Communicating with patients using avoidance or denial	1. Exclude misunderstanding and determine if avoidance is adaptive or maladaptive 2. Provide information tailored to the patient 3. Explore emotional reactions with empathy 4. Challenge inconsistencies explore factors enhancing adherence to recommended treatments 5. Respect patient's stance and follow-up to monitor carefully
Communicating about survivorship	1. Introduce survivorship care plan for patient and their general practitioner 2. Review diagnostic features and summarize treatments delivered 3. Identify any long term effects and strategies to manage these (e.g., sexual, reproductive) 4. List on a survivorship care plan any late effects and strategies to recognize early (e.g., secondary cancers) 5. Review any cancer screening and health promotion strategies to reduce risk for late effects 6. Ensure genetic counseling and family advice covered 7. Consider insurance, employment and financial implications

(continued)

Table 2 (continued)

Module	Strategies
	8. Check for any unmet needs or unanswered questions 9. Describe follow-up plan for future appointments and with whom
Communicating about recurrence of cancer	1. Review understanding of tests, extent of spread and need for treatment 2. Respond empathically to emotion 3. Ascertain interest in discussion of prognosis and tailor response 4. Acknowledge uncertainty 5. Discuss treatment options, future clinical trials and preferences for management 6. Summarize action plan and check understanding
Conducting a family meeting	7. Planning and prior set up to arrange the family meeting 8. Welcome and orient the family to the goals of the meeting 9. Check each family member's understanding of the illness and its prognosis 10. Check for consensus about the current goals of care 11. Identify family concerns about their management of key symptoms or care needs 12. Clarify the family's view of what the future holds 13. Clarify how family members are coping and feeling emotionally 14. Identify family strengths and affirm their level of commitment and mutual support for each other 15. Close the family meeting by final review of agreed goals of care and future plans
Discussing palliative care and the process of dying	1. Recognize patient's cue or emergent clinical reality 2. Establish understanding of disease progression, treatment efficacy and prognosis 3. Discuss patient's values and lifestyle factors that may impact on goals of care; negotiate appropriate if need be new goals of care 4. Respond empathically to emotion 5. Negotiate the shift to discuss the process of dying 6. Promote understanding of change–illness transitions–and role of courage in accepting one's dying 7. Address caregiver's concerns 8. Effect referral to palliative care service whenever appropriate 9. Close consultation
Communicating with patients via interpreters	1. Introduce the content and expectations of the consultation with the interpreter 2. Elicit interpreter's knowledge about the patient 3. Establish the doctor–patient–interpreter team 4. Explore culturally held health beliefs 5. Promote effective interpretation throughout the consultation 6. Review the consultation with the interpreter

Each strategy is implemented through concrete process tasks and individual skills

summarizing information. Skills can be applied to all areas of health care. There are six broad clusters of these skills, agenda setting, questioning skills, information giving, checking understanding, reaching shared decisions, and empathic responses (Brown and Bylund 2008).

In addition, there are contextual aspects which bear relevance to the initiation and maintenance of doctor–patient consultations. These are called process tasks. Process tasks can be verbal or nonverbal behaviors or dialogs, which create an atmosphere that is beneficial for effective communication. Process tasks can be very simple, e.g., creating a quiet and undisturbed setting for breaking bad news, but they can also be complex, e.g., avoid premature reassurance.

By observing and internally processing patients' verbal and nonverbal behavior, clinicians can form hypotheses about patients' unstated needs and intentions. This process of cognitive appraisal determines which communication strategies, skills, and process tasks the practitioner may choose to achieve the communication goal at hand. Although doctors use cognitive appraisal continuously throughout the communication process, COMSKIL focuses on two particular aspects: patient cues and patient barriers.

Patient cues are indirect behaviors which, if recognized, prompt the clinician to address a certain issue. In this way, a patient may state that they know little about a particular treatment (informational cue) or mention that they cry frequently (emotional cue) without directly asking for information or emotional support.

Patient barriers are concealed perceptions which prevent the patient from communicating openly about an issue and may thus thwart an effective decision-making process. For instance, a patient may have an exaggerated or particularly threatening impression of a treatment's side effects and, as a consequence, avoid discussing this treatment with their doctor.

The COMSKIL communication program consists of ten modules (Table 2) (Bialer et al. 2011; Brown et al. 2010a, b; Di Lubrano Ciccone et al. 2010; Gueguen et al. 2009; Kissane et al. 2017; Levin et al. 2010b). The program is usually taught in small groups during a 2-day workshop, where each group can be optimally facilitated by two instructors, one from the discipline of the trainees and the other from a psychosocial discipline. The emphasis lies with practicing communication skills through role play with simulated patients. For every module, there is a booklet, which forms the basis of the workshop and helps participants prepare. In the first module, the general framework of COMSKIL is laid out and general communication skills necessary for successful communication are explained. The other modules focus on specific but common clinical encounters, which have different goals and therefore require different skills by the doctor. Besides concrete examples to illustrate specific situations, there will be a variety of clinical scenarios available, which serve as the basis for the role playing exercises. A particular advantage is the use of specially trained actors as simulated patients to ensure that the role play is as realistic as possible, while preserving a protected space in which doctors can experiment with different techniques without risk of harm to a real patient. In this small group work, to create a protected, validating setting, which enables an intensive learning experience, there should be no more than six

participants. This also makes it possible for clinicians to reflect upon their personal experiences in the role playing exercises. However, when the module focuses on running family meetings, and four simulated patients may form the family for this experiential exercise, a fish bowl setting is utilized, in which the members of the small breakout groups are combined to form a larger observing group. Trainees are then rotated to take turns facilitating the family meeting.

4 Facilitator Training

Educators who provide CST to oncology trainees need to build their own skill base in the effective delivery of this experiential training (Bylund et al. 2008). Using a train-the-trainer model, instructors engage facilitators to define learning goals for each trainee and to build their literacy in the skills, strategies, and tasks that equip them to become optimal communicators. Facilitators establish guidelines for the safety and confidentiality of CST. They brief as necessary the simulated patients to role-play accurately and bring forth nuanced segments of desired intensity that will suit the learner's personal goals (Heinrich 2017). They use a stop–start technique that runs short segments of role-play, video recording for playback and learner review to promote reflection. They facilitate small group appraisal to identify strengths and opportunities for improved communication in the encounter (Manna et al. 2017). Most importantly, they guide the learner to rerun the segment, compare the outcomes, and thus experience a growing sense of mastery of the communication goal. Learners often have an "a-ha" moment as they gain new insight through the use of strategies, skills and process tasks that help them to more competently pursue the communication challenge at hand (Levin et al. 2010a).

Empirical work has established how facilitators can be trained and standardized to generate reproducible facilitation skills and sustain competence in creating a worthwhile learning experience for their trainees (Bylund et al. 2009). Facilitators from the trainee's discipline bring local expertise in the science of that discipline, while psychosocial facilitators bring wisdom and guidance in empathic communication to build an appropriate blend of skills to the advantage of each learner. Facilitators take responsibility for the safety of role-play and guide the small group feedback to be nurturing and constructive for the benefit of each learner.

5 Conclusion

Communication training is vital in oncology and palliative care to develop effective skills in clinicians serving our patients. The existential threat of cancer, related uncertainty, and the complexity of available treatments make this especially pertinent to this field. Experiential training of sufficient dose is critical to this skill development. The COMSKIL model provides a structured CST process wherein

trainees learn a language and a reflective method to equip them with an approach that will continue to serve them as their career unfolds. The curriculum has expanded to cover all phases of a patient's journey with cancer. The empirical evidence to support such CST grows ever stronger and more robust. A nursing curriculum has now emerged (Kissane et al. 2017). A number of applied modules have been developed to deal with unexpected adverse surgical outcomes, enrolment in clinical trials, treatment adherence, communicating genetic risk, discussing unproven therapies, communicating with ethnically diverse populations, and so on. The importance of the facilitator's skill and art for the learner is now clear (Lim 2017). CST is established as a crucial and clinically meaningful dimension of advanced training in quality cancer care.

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