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Original Paper

Helping Health Professionals Involved in Cancer Care Acquire Key Interviewing Skills—The Impact of Workshops

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To assess the impact of workshops on key interviewing skills, 169 health professionals involved in cancer care interviewed a simulated patient immediately before and after the workshops and 6 months later. Each interview was audiotaped, transcribed and rated by trained raters using a newly developed rating system which permits an utterance by utterance analysis. The workshops led to significant increases in the use of three behaviours which promote patient disclosure of key concerns. Namely, open directive questions, questions with a psychological focus and clarification of psychological aspects. However, there was no increase in the use of educated guesses and empathic statements which promote disclosure of key problems and feelings. There were significant reductions in behaviours which inhibit disclosure including the use of questions with a physical focus, utterances clarifying physical aspects and the giving of advice prematurely. These significant gains were still evident 6 months later, but there had been some decline over time. There were also significant improvements in the ability of health professionals to elicit patients key problems. Before the workshop, 75 (44%) participants were able to identify at least 60% of their patients' main problems (a criterion of clinical competence) compared with 119 (70%) at 6-month follow-up, an increase in numbers of 59%. Before training, health professionals used as many behaviours which inhibit disclosure as those that promote it. This was unaffected by their professional discipline, prior training or age. It highlights the need for health professionals involved in cancer care to have training in these communication skills. We believe that more intensive group work in smaller groups which focusses on the feelings and attitudes of participants as well as their interviewing behaviour would lead to an increase in the use of educated guesses and empathy and better exploration of patients' feelings. Copyright © 1996 Elsevier Science Ltd

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INTRODUCTION

A SUBSTANTIAL minority of patients with cancer develop a generalised anxiety disorder or depressive illness within the first few years of diagnosis [1]. Unfortunately, this morbidity is detected and treated appropriately in less than half the patients affected. Direct scrutiny of interactions between health professionals involved in cancer care and patients has found that this is due to two main factors [2, 3]: a lack of training in key interviewing skills and fears about the adverse consequences of enquiring about patients' reactions to their predicament. Moreover, health professionals also have difficulty eliciting patients' key concerns about their illness and treatment [4]. This is a serious problem since the number and severity of patients' unresolved concerns predict the later development of anxiety and depression [5].

Efforts need, therefore, to be made to help health pro-

fessionals acquire the relevant interviewing skills. Residential workshops were established and a study carried out to test hypotheses about which skills most promoted patient disclosure and which inhibited it. This confirmed that certain skills promoted disclosure of important concerns while other behaviours blocked disclosure [6]. This study aimed to assess whether these residential workshops helped health professionals improve with respect to these positive skills while reducing their use of inhibitory behaviours.

MATERIALS AND METHODS

Workshops and subjects

These were residential and of 3 or 5 days duration. They were multidisciplinary and attracted doctors, nurses, social workers and some chaplains. Each workshop was limited to a maximum of 20 participants [7]. The sample included all those health professionals who attended one of a consecutive series of 12 workshops. Of the workshops, eight were of 3 days duration and sponsored by the Extra Mural Department of

Manchester University. The remaining four workshops were of 5 days duration and sponsored by Help the Hospices. Each workshop was followed by a consolidation 2-day workshop 6 months later.

Participants were first asked to identify the communication tasks they most wanted help with in relation to communicating with patients, relatives and colleagues. They were then invited to put their agenda in order of priority to ensure that the most important issues were dealt with within the time limits available. Typical communication problems raised by participants were breaking bad news, eliciting and discussing patients' feelings about their diseases and confronting colleagues about unacceptable behaviour.

A videotape demonstrating a model of assessment was then shown and discussed to highlight the behaviours that promote disclosure and those that inhibit it. The participants then divided into two smaller groups of between eight and ten participants to practice specific communication tasks through rôle play and feedback led by an experienced facilitator. The workshops also included a session on how to survive emotionally when communicating more effectively and one on unfinished business (that is, items on the agenda that had not been dealt with in rôle play). A further videotape was shown demonstrating how to break collusion.

Assessment

Before any teaching was given, each participant was asked to interview a simulated patient for 20 min to determine the patients' current problems. The interview was ended after 20 min if the participant failed to do so.

Simulated patients were used because this allows the complexity of patient histories to be controlled while providing a realistic measure [8, 9] of how health professionals interact with real patients.

After the workshop, each participant was asked to carry out another assessment with a different simulator to assess skills after training.

Simulated patients

These had experienced cancer themselves but recovered from it or had experienced it in close relatives. They were used only if they were judged to have worked through their experiences sufficiently to be able to cope with these simulations and could represent their experiences as though they were happening currently.

The simulated patients were then helped to develop a realistic history. Since these were based on real life they naturally contained problems (physical, social, psychological, spiritual) which represented the range of cancer patients' concerns [6].

Measurement

Each interview was audiotaped and transcribed to permit later rating by trained raters. The raters used a detailed manual (Booth and Maguire, Report to Cancer Research Campaign, 1989). The aim of the rating was to assess the form, function and content of each patient and interviewer utterance as well as the emotional level of patient utterances. Emotional levels were rated at 0 (facts only), 1 (hints at feelings), 2 (mentions feelings), or 3 (full expression of feelings).

The content of each utterance was rated according to predefined categories (causes of disease, diagnosis, prognosis, other

experience of cancer, care given, family, finances, general health, information needs, social life, support, physical symptoms, psychological symptoms, treatment and adverse effects).

Information rated 'significant' included mention by the patient of concerns about diagnosis, prognosis, or adverse physical, psychological and social sequelae of their disease and treatment. Counts of significant content and emotional level were expressed as a percentage of all utterances by the patient within each interview. Health professionals' behaviours were expressed similarly as a percentage of all utterances by the interviewer.

Analysis

The Wilcoxon matched pairs test was used to compare pre- and postworkshop assessments and pretest and 6-months follow-up data. For these comparisons, the 3- and 5-day workshop data were pooled. The relative impact of the 3- and 5-day workshops will be reported separately.

RESULTS

Sample

212 health professionals attended the workshops. Because of tape recorder failure, only 206 (97%) were assessed before and after the workshops. 169 (80%) health professionals attended the follow-up workshops 6 months later and completed an assessment immediately beforehand. These 169 participants comprised 39 doctors, 116 nurses, nine social workers and five other disciplines (including clinical psychologists and chaplains). 105 participants had attended 3-day workshops while 64 had workshops lasting 5 days.

Inter-rater reliability

After training of the two raters, three transcripts were selected at random to assess inter-rater reliability. They contained 322 interviewer and 431 patient utterances. Good agreement was obtained for form (91%), function (81%), content (87%) and emotional level (82%). After this initial check of inter-rater reliability, regular checks were carried out to ensure that high levels of agreement were maintained.

Less than a fifth (17%) of patients' utterances explicitly mentioned any feelings about their predicament. In most interviews, there was no actual expression of feelings (Table 1). The use of behaviours known to facilitate disclosure (open directive questions, questions with a psychological focus, clarification of psychological aspects, educated guesses and empathy) was infrequent. (Table 2). Behaviours which inhibit patient disclosure were used more frequently (leading questions, questions with a physical focus, clarifying physical aspects and the giving of premature advice) (Table 3).

Skills after training

After training, there was a significant increase in the use of open directive questions, questions with a psychological focus and clarification of psychological aspects (Table 2). However, there was no increase in the use of educated guesses or empathic statements.

There was a significant reduction in the use of questions with a physical focus, clarification of physical aspects and premature advice (Table 3). However, there was no reduction in the giving of advice or the use of leading questions.

More hints and mention of feelings were evident in patients' utterances after training (Table 1).

Table 1. Scores of patient disclosure *n* = 169 (median and range)

	Before training	After training	6 months
Level 0 (Facts only)	41.0 (18.6, 79.9)	33.2* (7.4, 84.1)	31.0* (9.6, 72.5)
Level 1 (Hints at feelings)	37.6 (13.1, 68.1)	41.9† (7.8, 70.8)	43.6* (19.6, 68.7)
Level 2 (Mentions feelings)	16.9 (0.0, 49.5)	19.0† (0.0, 57.6)	20.1* (2.4, 52.2)
Level 3 (Full expression)	0.0 (0.0, 11.5)	0.0 (0.0, 9.2)	0.0 (0.0, 10.6)
Significant content	45.0 (5.6, 88.4)	51.8* (16.3, 87.2)	52.7* (6.7, 80.0)

Compared with scores before training; **P* < 0.001, †*P* < 0.01.

Table 2. Interviewer behaviour changes (facilitative) *n* = 169 (median and range)

	Before training	After training	6 months
Open directive questions	5.8 (0.0, 37.7)	10.4* (0.0, 38.3)	8.1* (0.0, 32.0)
Questions with psychological focus	6.9 (0.7, 36.2)	12.9* (1.0, 36.8)	10.3* (0.7, 32.4)
Clarification of psychological focus	2.9 (0.0, 18.2)	4.9* (0.0, 31.1)	3.9* (0.0, 23.5)
Educated guesses	2.7 (0.0, 16.2)	2.5 (0.0, 16.9)	2.6 (0.0, 10.9)
Educated guesses negotiated	0.0 (0.0, 9.1)	0.0 (0.0, 5.2)	0.0 (0.0, 4.4)
Empathy	1.4 (0.0, 12.2)	1.6 (0.0, 11.8)	1.5 (0.0, 12.2)

Compared with scores before training; **P* < 0.001.

Table 3. Changes in interviewer behaviour (inhibitory) *n* = 169 (median and range)

	Before training	After training	6 months
Leading questions	0.0 (0.0, 6.7)	0.0 (0.0, 8.9)	0.0* (0.0, 6.4)
Questions with physical focus	13.8 (2.9, 32.4)	9.7* (0.5, 30.6)	11.3* (0.0, 34.7)
Clarifying physical aspects	5.9 (0.0, 18.4)	3.3* (0.0, 19.2)	4.2* (0.0, 22.7)
Giving advice	2.4 (0.0, 29.3)	2.0 (0.0, 21.3)	2.7 (0.0, 21.2)
Premature advice	1.5 (0.0, 30.4)	0.0* (0.0, 19.8)	0.6* (0.0, 17.9)

Compared with scores before training; **P* < 0.001.

Six months after training

Compared with performance before training, the use of open directive questions, questions with a psychological focus, and clarification of psychological aspects were still significantly better. However, there had been some decline compared with the postworkshop scores, while there was no change in

educated guesses or empathy (Table 2). There was no decline in the extent to which patients hinted at or mentioned feelings (Table 1).

Compared with the preworkshop scores, participants still used questions with a physical focus, clarification of physical aspects and premature advice less frequently, but use of these

inhibitory behaviours was increasing towards the preworkshop level (Table 3).

The level of significant information obtained increased by 20% (Table 1). The clinical relevance of this was that the numbers of participants able to identify the majority (60%) of the patients' problems rose from 75 (44%) before the workshop to 119 (70%) at follow-up, an increase in numbers of 59% (44/75).

The extent to which health professionals' use of key skills and inhibitory behaviours before training bore no relationship to their professional discipline, prior training or age.

DISCUSSION

The finding that our workshops improved the use of skills associated with patient disclosure and reduced the majority of the inhibitory ones is encouraging, particularly as the gains were still evident 6 months later. Moreover, this led to a worthwhile increase (59%) in the number of participants able to elicit the majority of the patients' key problems and worries. This is important since it may enable health professionals to prevent the later development of anxiety and depression by resolving these problems early in a patient's illness.

It could be argued that the gains obtained were merely due to a practice effect. A quasiexperimental study was conducted to test this. All 72 participants from four workshops were included. In the first workshop, they only did an assessment interview before training. In two workshops, participants were randomised to pre- and postworkshop interviews or a postworkshop interview only. In the remaining workshop, participants conducted a postworkshop interview only. Comparison between pre- and postworkshop scores showed consistent and significant improvements in validated skills and a decline in undesired behaviours. These changes were unrelated to whether or not participants had done an assessment interview before the workshop (Maguire and Hopwood, report to the Cancer Research Campaign).

It is possible that our workshops were attended by health professionals motivated to improve their communication skills and that similar gains would not be achieved with less motivated individuals. However, medical students and doctors responded well to similar feedback methods when given no choice about participating in training in interviewing skills [9, 10].

It was noteworthy that there was no increase in the use of empathy and educated guesses. Inspection of the transcripts found that the better clarification of psychological aspects and greater mention of feelings was accompanied by use of blocking behaviours by the health professionals. It appeared that the more effective they became in eliciting feelings the more worried they became of exploring patients' feelings further.

At the follow-up workshops, these health professionals offered several reasons as to why there had been some decline in their skills. Some cited a lack of practical and emotional support, and these factors have been found to be important determinants of interview behaviour [11, 12]. Others said they were still afraid of harming the patient psychologically if they probed in depth. They were not convinced that such enquiry would be beneficial for the patient or themselves. These concerns have been reported to be an important source of stress in health professionals working with cancer patients [13]. This suggests that our workshops need to pay more

attention to the attitudes and feelings of participants, particularly their worries about harming patients and perceived negative effects to themselves. Fears of death and dying also need attention [13, 14].

We believe these aims could best be achieved by reducing the size of the small groups from eight to ten participants to four or five and ensuring that each group is led by a trained facilitator. These smaller groups would provide a much greater opportunity for participants to practice specific skills and tasks and a safer environment in which to explore feelings and attitudes provoked or exposed by practicing particular skills and tasks. Even if these approaches are successful, we still have to find ways of ensuring that the newly acquired skills are maintained and applied in the workplace for the benefit of patients and health professionals alike.

The cost effectiveness of these teaching methods was not evaluated formally. Although the four Help the Hospice workshops were subsidised heavily, their 5-day workshops were no more effective than the Extra Mural 3-day courses. This emphasises the need to compare the costs and impact of different approaches.

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