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Improving Communication with Cancer Patients*

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If doctors and nurses involved in cancer care are to help patients and their families achieve an optimal level of quality of life and psychological adjustment they must be able to carry out key communication tasks successfully. Yet, objective scrutiny of their consultations confirms that deficiencies in their ability to conduct these tasks remain. The reasons for this are dicussed before important innovations in training and their impact are described.

Key words: breaking bad news, training in communication skills, barriers to communication
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INTRODUCTION

How doctors and nurses communicate can profoundly affect the psychological adjustment and quality of life of cancer patients and relatives [1, 2]. Unfortunately, few doctors and nurses receive sufficient training to ensure they are proficient in key communication tasks [3–5]. Doctors who perceive their training in communication skills was inadequate appear at risk of burnout, anxiety and depression [6]. This may further impair their management of patients and relatives. These problems in communication have prompted research into the reasons for them and the development of new training methods.

This review first considers deficiencies in the conduct of key communication tasks and their consequences. The reasons for these deficiencies are then explored before recent communication and training initiatives are discussed. Finally, likely developments in the next millennium are suggested.

KEY COMMUNICATION TASKS

Eliciting patients' key problems, perceptions and feelings

Weisman and Worden [7] found a link between patients having more concerns after diagnosis and high levels of emotional distress 6 months later. A strong relationship was also found between the number and severity of patients' concerns in the first 4–8 weeks after diagnosis and the later development of clinical anxiety and depression [8, 9]. Thus, a key task for health professionals assessing cancer patients is to ensure that they elicit their main concerns whether they are

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physical, social, psychological or spiritual and attempt, where possible, to resolve them.

In practice, a substantial number of patients' concerns remain undisclosed. Stewart and colleagues [8] found that only 40% of the concerns of women with cervical cancer had been disclosed during the year after diagnosis. In a study by Heaven and Maguire [10] hospice patients had an average of seven concerns but only three of these had been disclosed to hospice staff.

The extent to which the initial consultation with patients is patient-centred is also important [11]. When doctors elicit patients' reasons for presenting, their perceptions of their problems and reactions, and the impact on their daily lives, patients feel more satisfied and comply better with offered advice and medication. Yet, objective studies of interactions between doctors and cancer patients have found that doctors spend little time probing psychosocial aspects [12]. Wilkinson [13] found that coverage of these aspects by cancer nurses was very poor or non-existent. Moreover, 50% of their utterances had the function of trying to stop patients disclosing their concerns. These blocking behaviours have also been found in experienced cancer doctors and nurses in the clinical [14] and training setting [15].

SUMMARY: The number and severity of patients' concerns predicts later psychological distress, anxiety and depression. Only a minority of patients' concerns are elicited in clinical practice. Patient-centred interviewing behaviours are important but used infrequently.

Breaking bad news

Guidelines. A key question is how should bad news be broken. Girghis and Sanson-Fisher [16] drew up guidelines on the basis of a literature review and the recommendations of a consensus panel of doctors and cancer patients.

Their guidelines included:

Ensure privacy and adequate time
Assess patients' understanding
Provide information about diagnosis and prognosis simply and honestly
Avoid euphemisms
Encourage patients to express feelings
Be empathic
Give a broad but realistic time frame concerning prognosis
Arrange review

Miller and colleagues [17] came to similar conclusions but disagreed about euphemisms. They considered they should be used when patients had no awareness of their diagnosis to test if patients were ready to hear the full diagnosis. Their review concluded that while there was a good consensus about guidelines they had little scientific basis.

Behaviours in practice. In a study of experienced cancer specialists breaking bad news [18] consultations have been analysed to see whether these guidelines are followed.

In most consultations patients' thoughts and feelings about their predicament were not first elicited. Bad news was given in a routine way. Patients were told the diagnosis, the evidence for that, need for further tests, likely treatments to be given and the probable outcome, regardless of which issues patients wished to address.

After giving bad news there was no pause to allow patients time to respond. Obvious distress was not usually acknowledged. Patients were not actively invited to say how they were feeling and what their main concerns were. Yet, unless patients were given a chance to disclose and talk about their main concerns before information was offered they remained preoccupied with them. They did not listen to the offered information and were more likely to develop an unduly negative appraisal of their situation.

Patients' views. Most cancer patients want to know if they have cancer, their likely treatments, side-effects and prognosis [19]. Only a minority do not wish to know, especially the elderly, those having a poor prognosis, and coming from deprived areas.

The extent to which patients perceive that the information given was adequate has also been linked to better psychological adjustment in breast cancer patients [20]. In contrast, those who felt they were given too much or too little information had a higher risk of anxiety and depression one year later.

Despite these data favouring disclosure a substantial number of doctors, at least in Europe, avoid telling patients the truth [21]. Although it is often argued that patients' desire for truth is culturally determined, recent work suggests this may be untrue. Fielding and Hung [22] interviewed 1036 Hong Kong Chinese people. 95% of them wanted to know the diagnosis, even if it was poor, whilst 95% did not agree with the practice of collusion where relatives were told the diagnosis but not the patient.

SUMMARY: Most cancer patients want to know their diagnosis, prognosis, possible treatments and relevant side-effects. A minority, particularly those who are older, have a poor prognosis, or come from deprived areas prefer not to know. There is a discrepancy between patients' wishes and the way doctors deliver bad news. Doctors do not acknowledge patients' distress, ask directly about their concerns, probe into psychological and social aspects, or establish individual patients' needs for information. Instead, they rely on a routine way of giving information. This increases the risk that patients remain preoccupied with their concerns, fail to assimilate what is said and perceive the information given as inadequate. This increases the risk of a negative appraisal, anxiety and depression.

Involving patients in treatment decisions

Recent studies have shown that patients differ in the extent to which they wish to be involved in treatment decisions. Degner and associates [23] surveyed 1012 women with breast cancer who were visiting oncology clinics. Twenty-two per cent preferred to take the lead, 34% wanted to leave it to the clinician to decide whilst 44% preferred to share in decision making. Rothenbacher and associates [24] surveyed cancer patients in palliative care and patients with non-cancer conditions. The majority in all groups preferred a collaborative role. Unfortunately, less than half of cancer patients achieved their preferred level of control [23]. Physicians' estimates of the preference of patients with advanced cancer for involvement in decisions were no better than chance [24].

Early studies [25, 26] found that offering choice of treatment and going with the patients' preference reduced anxiety and depression. Fallowfield and colleagues [20] suggested it was not being involved in choice that was important, but rather patients feeling that they had been given adequate information about their situation. Whilst offering choice may increase patients' satisfaction and compliance, it may leave patients feeling they have an undue burden and responsibility. They may blame themselves if the treatment does not work, lose confidence in the doctor and experience uncertainty and confusion [27]. Further larger-scale studies are needed to see if positive outcomes result from the better ability of clinicians to identify and follow patients' preferences for involvement and choice.

SUMMARY: Patients' willingness to be involved in decisions about treatment vary considerably. The clinician has to identify how much patients want to be involved in decisions regardless of disease stage.

Obtaining informed consent

It has been argued [28] that patients must be given adequate information about the aims, methods and benefits versus hazards of specific treatment. It should be explained that they are free to decline the treatment and consent should be obtained orally and by written consent. However, patients may become distressed if they are given too much information when they do not want it, especially when the risks of serious adverse effects are low. The wishes of some patients for full versus minimal information may reflect a personality disposition [29].

Using a questionnaire, gynaecological patients about to undergo colposcopy were divided into information seekers (monitors) and avoiders (blunters). Half in each group were exposed to detailed information and half to the usual low level of information. Blunters were less aroused when presented with low levels of information and monitors were less aroused by high levels of information. The extent to which these concepts are relevant in clinical practice and doctors and nurses are able to vary their communication styles accordingly has to be determined.

In a study of non-cancer patients, Kerigan and associates [30] studied men about to undergo an elective repair of an inguinal hernia. Patients were randomised to receive very detailed or simple information. No greater levels of anxiety and depression were found in those given very detailed information. However, these were not patients facing life-threatening illnesses and the procedures were elective.

In some countries the law demands that clinicians give all relevant information about problems and advantages of a specific treatment. In other countries it is still possible for clinicians to determine how much or how little patients want to know. The psychological impact of these differing approaches has still to be compared.

Litigation is more likely when patients feel they were given inadequate information about the benefits versus hazards of procedures [31]. Yet, there is often a mismatch between the information given by doctors and nurses to patients and their actual information needs [31, 32].

Trying to enter patients into randomised control trials can lead to difficulties in communication. Fallowfield and associates [33] used a questionnaire to assess the attitudes of cancer patients to being entered into randomised clinical trials. The majority (91%) believed that patients should be asked about their willingness to enter and 77% said they would participate if the trial involved compared two treatments. Only 45% would agree to take part in a randomised trial. Some of those who rejected randomised trials said they might participate if randomisation was explained properly. There are few objective data to show how effectively doctors determine which group patients come into and whether or not they heed patients' wishes rather than use persuasive modes to recruit them into trials.

SUMMARY: There is often a mismatch between information given to cancer patients and their needs, particularly when the law insists on full information. The impact of taking patients' needs and personality into account merits further study.

Monitoring adverse reactions

Up to one-third of patients diagnosed as having cancer develop clinical anxiety and/or depression [34–36]. Up to 25% develop body image problems, sexual difficulties or a combination of these [37]. Moreover, a substantial majority of patients develop adverse side-effects when undergoing major treatments like chemotherapy [38].

Cancer doctors and nurses underestimate the incidence of affective disorders in cancer patients. In one study [39] only 49% of those with major depression were recognised. Whilst 79% of those with anxiety were identified, this was at the cost of a high false-positive rate. Lambic and colleagues [40] compared the ratings by cancer patients of their anxiety with ratings by their physicians at follow-up clinics. Physicians over-rated anxiety in the non-anxious group but seriously underestimated it in those with moderately severe to severe anxiety. Similarly, there is substantial under-recognition of anxiety and depression in relatives [41, 42]. This failure to recognise affective disorders in patients is paralleled by a failure to recognise sexual problems and body image problems [43].

Whilst it might be expected that physical side-effects of toxic treatments like chemotherapy would be assessed more accurately, this is not the case [44]. Important key symptoms like pain are commonly underestimated [45, 46]. Serious discrepancies between pain reported by the patient and estimates by their caregivers and nurses have also been found in palliative care [47].

SUMMARY: The diagnosis and treatment of cancer is associated with substantial physical and psychiatric morbidity. These problems are under-recognised and undertreated.

BARRIERS TO EFFECTIVE COMMUNICATION

Patient-led

Patients are loath to disclose any psychological problems they have developed because they believe they are an inevitable consequence of having cancer and being treated for it [48]. Anxiety and depression are understandable reactions and there is no point in mentioning them as nothing can be done. They worry that if they disclose they are feeling anxious or depressed they will be viewed as "ungrateful and neurotic" by doctors and nurses caring for them. They perceive that carers are busy and do not wish to burden them further, especially when they have come to respect and like them.

Their reluctance to disclose concerns is reinforced by the behaviour of health professionals. Few doctors and nurses ask questions that make them feel it is legitimate to disclose psychological and social problems. They are not usually asked what they think or feel about diagnosis or treatment. It is rare for them to be asked how they have reacted to a specific treatment or how it has affected their daily lives, mood state and personal relationships. Consequently, they believe that health-care professionals are not interested in their real experiences.

Despite this lack of enquiry, some patients still give cues by mentioning they are upset, worried or troubled by pain. However, they perceive that doctors and nurses are reluctant to acknowledge and explore their cues further. They observe that health professionals attend selectively to physical aspects or use other blocking strategies.

Patients with cancer and their relatives should find it easier to tell their general practitioners about key problems. In reality, patients and relatives tend to devalue the role of general practitioners because they perceive that they have too little experience of cancer and are not up to date with current treatment regimes [49].

Professional-led reasons

Avoidance. Direct observation of interactions between doctors and nurses and patients with cancer during training in communication skills has confirmed that patients' claims are valid [14]. Open directive questions like "How have you felt about losing a breast?" are asked rarely. Questions about patients' perceptions of their predicament, for example, "How do you see things working out in the future?" are asked by only 1 in 20 of the healthcare professionals involved. Only one-third to half of patients' verbal cues about psychological aspects are explored. Instead, they use interviewing strategies designed to avoid patient disclosure of concerns and emotions.

Fears. Most health professionals acknowledge they avoid eliciting patients' perceptions of what is going on and their emotional reactions [14]. They do this because asking these questions might release strong emotions like despair which they would not be able to contain. It would take too much time and harm patients psychologically. They view patients as fragile and susceptible to harm rather than as robust individuals capable of working through their predicaments.

If they probe how the patient is adjusting they will be asked difficult questions like 'Can I be cured?' or 'Why wasn't it diagnosed sooner?' They would get much closer to how patients' and families' lives are being affected by cancer and treatment. This could be very upsetting, particularly when they identify with the patient and family and it might jeopardise their own emotional survival. So, it is better to keep the consultation in 'safe waters'.

Nor do they wish to be reminded of how uncertain the outcome of treatment for cancer can be or about the frequent failure of high technology medicine to achieve cure [49]. They have no satisfactory explanation to offer patients and relatives about why cancer developed and why treatment has failed. Many doctors and nurses dislike the combination chemotherapies used to treat cancers and do not wish to be reminded of this by asking about the nature and extent of side-effects and impact.

Lack of communication skills. Doctors and nurses attending workshops on key communication skills [5] readily acknowledge that their training in communication skills was inadequate. They indicate they most need help with breaking bad news, dealing with patients who had been lied to previously, eliciting patients' concerns and problems, dealing with difficult questions and angry patients. Fallowfield and colleagues [50] reported that the doctors attending their courses found the most difficult patients to handle were the young, adolescent or elderly; those with young children; those from ethnic minorities; and patients they identified with. The most common communication problems they experienced were giving complex information, obtaining informed consent, dealing with angry relatives, eliciting and dealing with psychosocial concerns, coping with patients' emotions and breaking bad news.

Lack of support. If health professionals feel they lack personal and practical support from colleagues and supervisors they are more likely to block patients' disclosure of their concerns [13, 51].

SUMMARY: Deficiencies in doctors' and nurses' ability to perform key communication tasks are due to inadequate training, and their fears of eliciting concerns, perceptions and feelings. The extent to which health professionals feel valued and supported by colleagues and supervisors is also a major factor.

IMPROVING COMMUNICATION WITH PATIENTS

Recent initiatives

Use of orientation programmes. A brief clinical orientation aimed at reducing anxiety, distress and uncertainty in a general adult oncology clinical population was developed and evaluated. 150 patients referred to an oncology outpatient clinic were randomly assigned to an intervention or the usual care control group. The intervention group received a clinic tour, general information about how the clinic operated and a question and answer session with an oncology counsellor. Two weeks later the intervention group had lower anxiety, lower distress and fewer patients reported depressive symptoms. They had more relevant knowledge and greater satisfaction with care [52].

Giving patients audiotape recordings of the bad news consultation and/or letters. A new approach to improving communication has been to give patients an audiotape recording or written summary of the consultation. They can review what was said, consider the implications, and share the information with family and key friends. It was hoped it would encourage them to ask questions at subsequent consultations and lead to better psychological adjustment.

For example, Dunn and associates [53] compared the effects of providing an audiotape of the consultation with a general information tape or no tape. No differences in psychological adjustment were found at follow-up and the consultation tape did not improve recall compared with the no tape control.

Whilst most participants and families seemed to value tapes of the consultation or summary letters, in only two studies was there evidence that consultation tapes improved patients' ability to recall information [54, 55], whilst in one study tapes worsened recall [53]. There was no evidence of a reduction in anxiety and depression, and in one study patients with a poor prognosis were more distressed after listening to the consultation tape [55]. The quality of the original consultation may be the key to these varying outcomes and these communication aids are probably no substitute for good consultation skills.

Sharing case records. Sharing records with patients may reduce problems in communication. Drury and associates [56] studied the acceptability of patients with advanced cancer holding their own shared-care records. The records allowed patients and care givers to record appointments, medications, and any significant events. In-depth semi-structured interviews with patients and carers found the majority claimed these records were helpful but only a minority wrote regularly in them. Caregivers and doctors appeared more aware of patients' feelings.

Developments in training

Identifying key interviewing behaviours. Work with general practitioners determined which interviewing behaviours distinguished doctors able to recognise patients with psychological morbidity [57]. Key behaviours included making good eye contact at the outset, clarifying patients' complaints, responding to verbal cues suggestive of emotional distress, asking questions about patients' feelings, enquiring about the situation at home, making supportive comments, handling interruptions well and maintaining eye contact.

A study of American doctors [58] replicated these findings and highlighted the value of directive questions, responding to non-verbal cues, being empathic, and the use of open to closed cones of questions. Davenport and colleagues [59] found that verbal rather than non-verbal cues given by patients were most indicative of psychological distress. Behaviours inhibiting patients giving cues included poor eye contact, reliance on closed questions and failure to respond to and clarify verbal cues about their problems.

Cox and colleagues [60] studying interviews with parents of children referred to a psychiatric clinic suggested that a proactive style of interviewing was optimal. Interviewers using open directive questions to raise new topics, requesting detailed and exact information, repeating and checking what parents said, were more effective in eliciting problems than those who encouraged parents to give their own story with few interruptions.

This was confirmed by Bensing and Sluijs [61]. General practitioners were trained to unlearn active behaviours and acquire more passive and empathic forms like giving more time, making more eye contact, reducing their own speaking time, appearing calmer and more interested. They were also trained to use more empathy, reflecting, exploring, offering feelings and indicating understanding. Although training led to these desired changes in doctors' behaviour, patients did not disclose any more psychosocial problems.

A key question was whether these findings about behaviours promoting or inhibiting patient disclosure of distress were relevant to cancer care and disclosure of other concerns. Early work evaluating the effects of counselling and monitoring of mastectomy patients had also emphasised the value of actively eliciting patients' feelings about key events ('How did you feel about chemotherapy?, losing a breast?') and responding to subsequent cues. Patients were more likely to disclose important problems like adverse effects of chemotherapy, fear of dying, body image problems, sexual difficulties, anxiety and depression [62]. A validation study was, therefore, carried out involving 206 health professionals attending 12 workshops on communicating with cancer patients. Key behaviours associated with greater disclosure by patients of their main concerns and feelings included asking patients about their perceptions and feelings, clarifying psychological aspects, using open directive questions, educated guesses, empathy and summarising [63]. Inhibition of disclosure was associated with the use of leading questions, closed questions, multiple questions, spending time clarifying physical aspects, asking questions with a physical focus, giving advice and premature reassurance.

Questions about physical aspects and clarifying them became a problem if more than a few minutes were spent asking only these without using any of the positive behaviours. Patients then felt 'programmed' that the doctor or nurse was only concerned with physical aspects.

Training methods. Work in training medical students in interviewing skills [64] found that these behaviours could be improved by training them individually or in small groups providing the following elements are included.

Handouts describing the explicit behaviours to be learned or extinguished.

A demonstration of these behaviours in action.

Practise under safe conditions.

Explicit but constructive feedback about performance.

Opportunity for further practise and feedback.

The skills learned from practice with psychiatric patients generalised to patients with life-threatening and chronic disabling physical conditions and the benefits lasted over time.

Three groups in Europe have attempted to train health professionals involved in cancer care in key skills and improve their ability to deal with difficult communication tasks such as breaking bad news. Maguire and Faulkner [5] developed multidisciplinary residential workshops of three or five days duration. It was hoped that the multidisciplinary nature of the workshops would improve learning. Participants set an agenda involving those communication tasks they found most difficult. Objective assessment found that these workshops led to participants acquiring most of the desired skills and relinquishing most of the undesired behaviours [15]. However, as participants got better at eliciting patients' concerns and feelings they reintroduced blocking strategies. Even so, they were much more able to identify patients' concerns compared with before training, whatever the nature of the concern.

More attention is now being paid to the blocking behaviours used by the doctors and nurses and discussion of the underlying reasons for these. The modified workshops have been successful in eliminating all the negative behaviours including blocking and helping health professionals acquire all the positive ones [65].

Fallowfield and colleagues [50] considered that training would be more effective when carried out within single disciplines. They trained doctors in one and a half to three day residential workshops. They paid attention to the feelings and concerns of participants in the hope this would accelerate learning. Their workshops have not been evaluated objectively but participants reported greater confidence in their ability to assess and communicate with patients and teach communication skills to others.

Razavi and colleagues [66] examined the effects of brief training on the attitudes of nurses to death and dying. They favourably influenced negative attitudes in the short term but these reverted back over the next year. When they extended the training to 24 h and included training in communication skills they again found a positive impact on health professionals' attitudes to themselves, terminal illness and cancer, personal growth, professional relationships and occupation. However, the nurses had reverted back 2 months later [67].

They found little change in interviewing behaviours except for those required to keep patients to the point. They argued that further consolidation sessions were needed to improve the acquisition of interviewing skills.

Bird and associates [68] followed the same approach as used by Fallowfield in a bid to teach consultants how to teach communication skills. Their workshops were three and a half days in duration, learner centred, residential, used lectures, demonstrations, and practise in small groups as well as the opportunity to participate in self-selected projects. Subjective feedback was good.

Cushing and Jones [69] evaluated a breaking bad news course with medical students. They trained groups of 6–10 students over a period of 2 weeks with a 3 hourly session each week. Students reported being very satisfied with the course. Other training initiatives have focused on specific outcomes like achieving better pain control. Francke and associates [70] randomised nurses by ward to a continuing education programme (24 h) or control group. Despite this training there was only a modest reduction in pain intensity and no change in pain duration, sleeplessness, anxiety or depression. This highlights the importance of checking if learning which results from workshops and courses is transferred to clinical practice and affects important patients' outcomes.

DEVELOPMENTS IN THE NEXT MILLENNIUM

Evaluation of training methods

In general practice Roter and colleagues [71] found that training had important effects on patient outcomes. They randomised general practitioners to 8 h training in emotion handling behaviours, problem defining behaviours or to a control group. Doctors trained in problem defining behaviours recognised 53% of those patients who had high GHQ scores compared with only 37% in the control group, whilst the emotion handling group recognised 46%.

There was a significant reduction in emotional distress in patients seen by the problem defined group compared with those in the emotion handling and control groups. Crucially, this was achieved without any increase in consultation time. Since at best only 53% of patients with 'probable caseness' were recognised by doctors after training there was still considerable room for improvement.

There is an urgent need for similar studies in the cancer field using rigorous methods of evaluation to show that training health professionals in key skills produces clinically relevant changes in patients and health professionals over time.

Randomised controlled studies in the U.K. and Europe are currently examining these issues and including important outcome measures like levels of burnout in doctors and nurses. If these confirm that training in communication skills leads to substantial benefits for patients, doctors and nurses, the case for such training will be strengthened.

Training issues needing attention

Dose–response. The training initiatives described have involved short residential workshops or courses. It is unclear what the optimal level of training is compared with the benefits. A comparison of 5- against 3-day workshops [15] found that 5-day workshops conferred no advantage because participants had felt saturated by the end of day 3.

An important initiative has been taken in Scandinavia where initial intense workshops have been followed by a series of follow-up workshops [72]. Subjective evaluation has suggested these may be particularly effective. However, the benefits of attending an ongoing course compared with a series of workshops utilising the same amount of time are unclear.

Transfer of learning. The extent to which gains in skills from workshops or courses predict performance with patients in daily practice as opposed to being able to reproduce the skills with real or simulated patients in a test situation is a major issue. Performance with simulators may more closely resemble what trainees are capable of rather than what they do in clinical practice [73]. The provision of support and supervision during the transfer period is likely to be important in ensuring the transfer of skills but has yet to be evaluated. Personal attitudes may also be influential. The American Academy for Doctor–Patient has argued that communication skills will only improve if health professionals participate in self-awareness groups [74]. Based on Bandura's work, Parle and colleagues [65] have suggested that focusing on participants' beliefs about their ability to deal with specific communication tasks (self-efficacy) and the benefits (outcome expectancy) are crucial to changing and maintaining communication behaviours. Studies are needed to determine how much changes in self-awareness facilitate or hinder skill acquisition and emotional survival.

Training in one versus several disciplines. The multidisciplinary approach has not been compared experimentally with the impact of training health professionals within a single discipline.

Training of facilitators. A major rate-limiting factor in improving communication skills in health professionals in cancer care is the availability of trained facilitators. In the Maguire programme, workshops designed to help teachers learn facilitation skills are held separately from those teaching communication skills. In contrast, Fallowfield combines the two. The American Academy of Doctor–Patient mentors potential facilitators by asking them to be co-facilitators over a 2-year period. Optimal methods of facilitator training remain to be determined although experiencing the teaching methods as a 'student' seems an important first step. Whatever approaches are evaluated it is important that they have a theoretical and scientific basis.

Information technology

The Internet. The Internet now allows patients and relatives to have rapid access to up to date information about their disease and treatment options. This makes it most important that doctors and nurses are able to explore what patients' and relatives' knowledge and understanding is before they seek to determine their remaining information needs, whether they wish to participate in decision making, or enter clinical trials.

Use of personal computers. Touch screens are now being used to administer questionnaires to assess quality of life, and patients' mood state. Even if these questionnaires produce data of high reliability and a high positive predictive value in identifying problems, second phase assessments of those scoring above specified thresholds will be necessary. But in practice there may be so many high scorers on questionnaires like the Hospital Anxiety and Depression Scale that it will not be possible for interviewers to conduct the necessary numbers of second phase assessments. It might be simpler and more cost-effective to train health professionals to ask the appropriate screening questions and to clarify the cues given. Touch screens may also have an increasing role in enabling patients to consider treatment options before talking further with the clinician.

The advent of managed care highlights the need for health professionals to be taught how to make maximal use of the time they have with the patient by communicating effectively and avoiding redundancy [75].

Monitoring by telecommunications (TLC). Monitoring of patients and their caregivers is now possible by computer-based telecommunications systems that converse with patients and other individuals in their home over the phone [76]. These systems supplement and complement visits between patients and their healthcare professionals. During telephone encounters this system speaks to patients using computer-controlled digitised human speech. Patients, in turn, communicate with TLC by depressing keys on their telephone keypad or by speaking into the telephone receiver. During each conversation TLC asks the patients clinical questions and comments on their responses. It can also provide information and counselling. For most TLC systems the responsible healthcare professionals receive routine reports that summarise the patients' status. TLC can also send alert reports to providers when the clinical condition warrants immediate medication. In some applications the patients receive regular reports that complement the content of the TLC conversations.

Further developments in training

Mandatory versus elective. Technology is unlikely to be any substitute for the better training of health professionals in communication skills. Apart from recent developments where communication skills training is included on courses for cancer nurses [77] most health professionals involved in cancer care only get training if they select to have it themselves. This is a major weakness which needs to be overcome. Moreover, training initiatives have generally been launched by individuals rather than institutions.

In the U.K., the Royal Colleges of Physicians and Surgeons are showing an interest in making training in communication skills mandatory for doctors and seeking to assess this by examination. Health professionals will then have to achieve the required standard. Valid but simple ways of measuring skills will be needed. The use of computerised systems may be the answer where raters can observe consultation behaviours and tap in their ratings on a keyboard. Examiners and trainees can then be given a profile of desired and undesired behaviours.

It is important that all health professionals involved in cancer care seek to improve their communication skills. Otherwise, psychosocial care and more difficult communication tasks will be left to specialist cancer nurses. They will then bear an undue burden and be at greater risk of burnout. How those who have no motivation to improve their communication skills can be helped remains a major challenge.

Distance learning. The use of distance learning to help people acquire basic communication skills and teaching skills could be a way forward. The further development of rating systems of interactions that could be computerised [78–80] could be useful in this regard providing they can be simplified. Doctors and nurses could then send in audio or video tapes of their consultations or teaching sessions to a training centre and receive feedback on their behaviours.

The new CD Rom systems should also allow them to learn by responding to actual video tapes or audio tapes shown from the teaching centre.

CONCLUSION

Much progress has been made in identifying deficiencies in communication with cancer patients and families and understanding the underlying reasons. Promising training initiatives have resulted, but their relevance to important patient and health professional outcomes has only recently become the subject of study. Methods of training facilitators have yet to be evaluated. The extent to which undergraduate and postgraduate training programmes ensure that sufficient facilitators are employed to train colleagues is uncertain. There is a danger they will continue to pay only lip service to training in communication skills.

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