Surviving the Stresses of Clinical Oncology by Improving Communication

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Armstrong and Holland's article provides a clear and concise discussion of many of the problems oncologists face in the high-pressure/high-stakes world of 21st century medicine. Physicians in general, and oncologists in particular, are overburdened with demands on their time, energy, and emotions. The authors present suggestions for relieving these stresses in the form of a "survival kit." The survival kit is interesting because it provides an education on how to communicate with patients and deal with the emotional aspects of practicing medicine.

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Over the past several decades, researchers from the field of cancer prevention and control have been arguing for a new paradigm of cancer care—ie, one in which communication between physicians and patients is restructured in order to effectuate a model of shared decision-making.[1] This model has two parts: (1) The physician and patient need to explicitly engage in decision-making; and (2) the information exchange needs to go both ways. Moreover, physicians need to provide patients with medical information (including specific information about prognosis, risks, and the benefits of available treatment options) that will allow them to make reasoned decisions. Despite the explicit acknowledgement that health communications are bilateral, research in this area has been largely patient-centered. That is, the research has centered on the needs of and potential health outcomes in patients when more sophisticated models of communication are employed.[2-6] In fact, few studies have measured outcomes for physicians beyond satisfaction or acceptability. **Effective Exchange of Information**

As Armstrong and Holland emphasize, all the issues that contribute to good outcomes in patients (knowing how to break bad news, understanding patients’ coping styles, successfully dealing with end-of-life care, disclosure of error) also enable physicians to function better and experience professional satisfaction. The communication process is the point of entry to successfully navigating these core oncology concerns. The primary goal of health-care communication is the exchange of information.[7,8] Providers and patients must seek and supply sufficient relevant information to diagnose and treat health-care issues. Exchange of information is not, however, always smooth, clear, or effective.[8] Studies indicate that clinicians are not good at perceiving their patients' needs for information or their psychological status.[9] We also know that the terminology used to communicate about cancer is often vague and obscures the information needed to make informed decisions, thereby affecting patients' subsequent emotional adjustment to illness.[2,9] Physicians and patients mutually construct the health-care interview, and both can learn to increase the effectiveness of this transaction. For example, Street et al.[8] have uncovered a number of interactive patterns that result in higher satisfaction and compliance. Expressive and assertive patients tend to ask more questions and, consequently, receive more information. In another study, patients who received more information also reported greater gains in knowledge.[7] Previous evidence suggests that patients typically ask vague and indirect questions, or no questions at all. However, patients can be trained to seek, verify, and provide information in direct and elaborative ways. When this occurs, physicians will ask more questions and verify more information with patients. Overall, this results in more information being exchanged between patients and oncologists.[7] **Physician Benefits**

Although the potential of the shared decision-making model is demonstrated by positive patient outcomes, such as greater satisfaction, increased adherence to treatment, and greater psychosocial adjustment,[4,5,10,11] my guess is that systematic study would demonstrate equally beneficial
outcomes in physicians. As Armstrong and Holland suggest, the doctor-patient relationship can act as a buffer to the psychosocial burdens of providing care to seriously ill patients within a system that makes increasing demands on the physician's time and skills. Investing in learning these skills will provide a direct payoff for physicians. We now understand that, over time, physicians develop communication styles that are molded by culture, professional demands, and situational expectations.[12] An oncologist's communication style will affect the tendency of that physician to engage in shared decision-making with patients. Similarly, patients' personal styles (and those of any significant others brought into the cancer consultation) affect their ability to work with physicians. Despite the potentially salutary benefits of effective communication for all parties, medical schools and residency training programs, unfortunately, continue to ignore this important component in the delivery of health care. Not providing the skills-based training needed to develop oncologists into effective communicators puts them at risk for burnout and other adverse outcomes.

**Conclusions**

Armstrong and Holland have made a strong case for paying greater attention to communication-for the sake of improved patient care and for the well-being of the oncologist. Their article is a clarion call to oncologists to systematically teach these skill sets to residents and fellows during training and to the health-care community to invest in health communication training for practicing oncologists. This article also presents a strong argument for researchers in the field to examine the communication equation from both sides—ie, assessing both patient and oncologist outcomes.

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