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REFLECTION

Difficult Conversations in Cancer Care: Lessons from a Student-Led Initiative

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Abstract
With the rising global burden of cancer, healthcare professionals will inevitably be involved directly or indirectly in the care of cancer patients. Although medical education has recently evolved to emphasise the biopsychosocial model, current training regarding difficult communication skills and breaking bad news remains inadequate. Our aim was to utilise a novel method of teaching communication skills through public engagement. This was achieved by setting up a local network of cancer patients who were willing to share their stories to aid student learning. A group of medical students from years one to four interviewed a total of 48 cancer patients about their illness experiences. Student reflections were collated, producing three common themes: (1) knowing what to say, (2) seeing the person in the patient, and (3) understanding the consequences of poor communication. The experiences allowed students to develop their communication skills, learn from patient experiences, and reflect on their future practice. Patient stories, including art, drawings, and poems, were collated in the form of a book and disseminated to promote further learning. We hope our reflections and public engagement initiative will identify key areas of difficult communication, enhance learning, and prepare students for meaningful and often difficult conversation in cancer care. Similar principles could be used in other areas of medical education to allow students to develop safe and effective interpersonal skills.

Keywords Cancer care · Communication skills · Empathy · Medical education · Public engagement · Student reflections · Undergraduate

Background

In 2018, there were over 18 million new cases of cancer worldwide, and these numbers are projected to rise by over 61% by 2040 [1]. The rising global burden of cancer poses a major challenge for oncology services worldwide. Oncology is a multifaceted discipline that requires a multidisciplinary approach involving medical, nursing, and allied health professionals from primary and secondary care. Healthcare students will inevitably be involved in the care of cancer patients and therefore require the emotional intelligence to effectively communicate and interact with such patients and their families.

Medical education has evolved over the last 25 years to emphasise the biopsychosocial approach to disease [2]. This model describes the impact of social behaviours and beliefs on health and disease [3]. The complex nature of cancer and its treatment emphasise the importance of this model. Patient health beliefs, adherence to treatment, experience of pain, and impact on everyday life may all be affected by a combination of biological, psychological, and social factors.

The University of Exeter Medical School uses a problem-based learning (PBL) approach, emphasising the biopsychosocial dimensions of care, to ensure that we take a holistic approach to each patient case encountered. In addition, we are given early clinical exposure and communication skills training. Despite this, clinical skills training at our medical school concerning breaking bad news, communicating in difficult circumstances, and dealing with grieving patients represent only 0.03% (4 out of 115) of topics across years one to four. This is also seen globally, with US medical schools dedicating fewer hours to oncology teaching compared to other areas of medicine [4] and a study of UK medical schools revealing that only 36% of medical schools include an oncology teaching block as part of their curriculum [5].

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Medical schools recognise the importance of difficult communication skills and frequently test them in medical school finals, such as in objective structured clinical examinations (OSCEs) [6]. These skills are key in directly addressing and exploring the patients' ideas, concerns, and expectations. However, a lack of confidence in these skills could result in healthcare professionals avoiding honest discussions with patients regarding cancer treatments or end-of-life care [7].

Worryingly, 31% of junior doctors recall meeting fewer than 10 patients with cancer throughout medical school [8]. Newly qualified doctors felt that they had learned the most about cancer through meeting real patients. Moreover, cancer patient encounters throughout medical school correlated with preparedness for practice [8]. Therefore, new strategies are required to maximise the meaningful exposure of students to cancer patients.

Public engagement in medical education has been shown to enhance student learning [9]. As healthcare professionals, it is clear that we need to form partnerships with patients and practice shared decision-making. Student-led public engagement initiatives have previously been successfully conducted to bridge the gap between the university and local community to provide effective public health education [10].

The aim of this project is to highlight the value of utilising public engagement in teaching communication skills. We believe that this model of teaching can be translated to all disciplines within healthcare, allowing students and healthcare professionals to develop safe and effective communication skills. In addition, this model indirectly benefits the volunteering group of patients through the creation of a local network of patients sharing stories and promoting honest conversations about cancer. Patients have previously described their encounters and conversations with students as being enjoyable, rewarding, and therapeutic. This article highlights reflections and key learning points from the students involved in the project.

Methods

In October 2016, we set up a collaboration between the Exeter Medical Leadership and Management Student Society and FORCE Cancer Charity. Using a team of 15 medical students from years one to four, we interviewed cancer patients and their carers within the FORCE Cancer Charity centre in Exeter.

Interviews were conducted in a private and comfortable environment to ensure patient confidentiality. Structured interviews were up to 1 h in duration. The first half of the interview focused on the patient's narrative, whilst the second half was led by the medical students who asked follow-up questions and recorded the patient's thoughts. All medical students were trained prior to the interviews by an oncology support specialist from FORCE Cancer Charity.

Between March 2017 and June 2018, students conducted 48 interviews. Patient stories were collected as various forms of art including narratives, poems, paintings, drawings, reflections, cartoons, and monologues.

Student perspectives were obtained through structured reflections upon completion of all patient interviews. Reflections were transcribed verbatim and qualitatively analysed using the framework method. The reflection transcripts were read by authors (HP, BCG, NMN), and common perspectives and thoughts were summarised into themes based on direct student quotes. The authors met and agreed the final themes used in the discussion. This method provided a systematic qualitative approach to interpreting student reflections to derive key themes to inform learning points using thematic analysis.

Results

Interviewing and listening to the stories of cancer patients has been an enriching learning experience for us all. Each student involved in the project had varying learning opportunities. This is demonstrated by the wide variety of experiences described by students, even between those who interviewed the same patient. This may be due to each student having different personal and professional perceptions of cancer.

Three distinctive themes have emerged from qualitative analysis of student reflections. The themes have direct quotes which define them. Our key learning lessons have been summarised alongside the thematic analysis in Table 1.

Knowing What to Say

> "A concern I have had, and I'm sure many others have, is knowing what the right things to say and do are. What if they ask me something I don't know the answer to?"

Healthcare professionals may fear not knowing how to respond to patients' emotions and questions such as "why me?". However, patients who ask these questions often know there is no singularly proper answer and the role of the healthcare professional in these situations is to often do nothing more than listen [11].

From our experience, silence is a key, yet difficult, aspect of breaking bad news. "Instinctively, I want to say something to the patient. During moments of silence, time seems to slow down and two minutes feel like an eternity!" added a fourth-year medical student.

Table 1 Thematic analysis of student reflections. Analysis of student reflections revealed three major themes and accompanying learning points

Theme	Defining quotes	Learning points
1. Knowing what to say	"A concern I have had, and I am sure many others have, is knowing what the right things to say and do are."	- It is okay to say "I do not know".
	"Instinctively, I want to say something to the patient. During moments of silence, time seems to slow down and two minutes feel like an eternity!"	- It is important to listen to patient concerns. - Appreciate the value of silence to give the patient time to think.
	"From my cancer patient encounters I have noticed that very often we are afraid to start conversations because we do not have access to enough information, do not know what the right answer is or we simply do not know what to say in a difficult situation."	- Acknowledge patient feelings and help them embrace uncertainty.
2. Seeing the person in the patient	"Patients have relationships, jobs and hobbies that are disrupted by a disease like cancer and its subsequent management. I know I personally now have a greatly improved awareness of this reality and can better understand what it means for a patient experiencing this."	- The patients' health is affected by medical, psychological, financial, and social factors. - We should encourage acknowledging the person behind the patient, by taking a thorough social history and asking about ideas, concerns, and expectations.
	"We sometimes forget that we are actually treating *people:* they are not just patients but they are mothers, fathers, daughters, and sons."	- We should encourage the use of social prescribing to support patients when possible.
	"Every story was a raw and brutally honest account of their lives, not just as a cancer patient but as much more: a mother, father, wife, husband, teacher, athlete, just to name a few."	
3.The consequence of caring	"As a doctor, who sees dozens of patients a day, I am sure it is often underestimated the life changing impact that just one interaction can have on a patient."	- Compassion fatigue, which can begin as early as the third year of medical school, can contribute to poor communication skills.
	"Throughout my upcoming years of study, remembering the patient's depth of gratitude and praise for their doctors will motivate me, to push myself harder, as I hope one day, I have the honour of being spoken about in the same way."	- The biomedical focus of the medical school curriculum can unfortunately. diminish the perceived importance of psychosocial factors. A problem-based learning approach aims to address this but still may overlook its importance. - We should not be afraid to seek help when we are struggling by confiding in those around us or seeking professional help.

Students taking part in our project were required to demonstrate this skill, since patients often became emotional whilst speaking about troublesome and personal parts of their life. Furthermore, students may bear expectations that they should know all the answers, when in reality this is not the case. An element of fear is hence tied to this facet of communication. This is a recognised barrier in breaking bad news [12]. However, students in their earlier years of training may not know all of the answers, and developing the ability to say "I don't know" is a skill in itself. Students involved in this project were often required to demonstrate this ability when patients discussed the complicated cancer regimens they are on. We believe that this will allow students to become more comfortable with the unknown, and therefore, become less afraid to express uncertainty to their patients in the future. Acknowledging the limits of your competence is a necessary skill as a healthcare professional [13]. This was reflected by a third-year medical student: "From my cancer patient encounters I've noticed that very often we are afraid to start conversations because we don't have access to enough information, don't know what the right answer is, or we simply don't know what to say in a difficult situation. […] But this [project] has taught me that we don't need to have all the answers and that it's okay to acknowledge when you don't know something".

Seeing the Person in the Patient

> "Patients have relationships, jobs, and hobbies, that are disrupted by a disease like cancer…"

During a medical consultation, the healthcare professional is often rushed to discuss the pertinent medical aspects of the patients care, such as blood results or treatment options. Therefore, the healthcare professional may not be given the opportunity to discuss the financial, psychological, and social

impacts of their illness. These factors may significantly impact health outcomes, for example by influencing the patient's health locus of control [14, 15]. The healthcare professional may have a role in identifying these issues and helping to manage them, such as through social prescribing. Social prescribing is a "non-medical referral, or linking service, to help people identify their social needs and develop 'well-being' action plans to promote, establish or re-establish integration and support in their communities, with the aim of improving personal wellbeing" [16].

> "We sometimes forget that we're actually treating people, they're not just patients but they are mothers, fathers, daughters, and sons."

It is very easy for a patient on the ward to become a number, a diagnosis, or a clinical sign. When clerking patients, students and clinicians often overlook the importance of some aspects of the social history such as religion, alternative healthcare practices, and stressors [17]. However, since social factors can contribute to patient's health outcomes [14], they are equally as important as the medical history. One student reflected, "I will now view every patient's case as an individual entity".

Interviewing patients with cancer and hearing about the impact their disease has on them gives us a unique insight into the effects of cancer on their emotions, their job, and their family. These are the things that make them human.

The Consequence of Caring

> "As a doctor, who sees dozens of patients a day, I am sure it is often underestimated the life changing impact that just one interaction can have on a patient."

Several patients that were interviewed described negative experiences of receiving bad news. The importance of breaking bad news in the right way cannot be underestimated and is reiterated throughout the literature. However, bad news can be given poorly, such as by providing too much information, which saturates the key information about the diagnosis, or by showing a lack of empathy [18]. This can result in severe psychological distress and may lead to subsequent affective disorders in patients with cancer [19, 20].

Although there may be a degree of recall bias, since the patient has been given devastating and life-changing news [21], the patient's account may have some truth to it and could be explained by the erosion of empathy. Erosion of empathy is a decline in the level of empathy as one goes through medical school and subsequent training [22]. The doctor becomes so accustomed to giving bad news that it becomes routine and may no longer evoke emotion.

This erosion of empathy may also be seen in medical students' views on disclosing information to patients. As students start medical school, their knowledge of the biomedical aspects of cancer, such as investigations, treatments, and prognosis, may be limited. However, they may have a stronger understanding of the psychosocial factors surrounding cancer, due to personal experiences. This may explain why first-year medical students are more likely to recommend giving patients all of the information about their disease, whereas third-year medical students prefer a paternalistic "non-disclosure" model [23]. However, patients often want to know all of the information about their illness, and withholding some of this information may affect the patients' perception of healthcare professionals [24, 25].

> "Throughout my upcoming years of study, remembering the patient's depth of gratitude and praise for their doctors will keep me motivated, as I hope one day I have the honour of being spoken about in the same way."

Interviewing patients as part of this initiative has given us a very privileged opportunity to learn from the negative experiences patients may have had with regard to the care that they received. Thankfully, these are not common, and many of the cancer patients that we interviewed made positive remarks about the healthcare professionals who treated them. Student reflections suggest that this initiative may contribute to future reductions in burnout and compassion fatigue amongst those involved.

Conclusion

This paper has reflected on the key issues involving difficult communication in cancer care. We have summarised three distinctive themes that can be used to inform future practice. Appreciating the importance of silence, seeing the person in the patient, and understanding the consequences of poor communication are the stepping stones in our developmental journey of achieving effective communication skills. This initiative has been beneficial for both the students involved and the patient volunteers. We have been able to use our interviews with patients to produce a cancer patient stories book that has been disseminated throughout the community. We hope that initiatives such as this can be implemented nationwide to build a collaborative culture where students learn with patients, for patients.

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