Surviving the Stresses of Clinical Oncology by Improving Communication

Review Article [1] | March 01, 2004
By Jennifer Armstrong, MD [2] and Jimmie C. Holland, MD [3]

Oncologists grapple with an element of psychological stress that relates to the suffering their patients experience. Although this stress may not be unique to oncology, it is profound. When these stresses become overwhelming, they lead to physician burnout. It is important to understand what makes an oncologist feel successful, what coping strategies help combat burnout, and what adds to the process of renewal. The doctor-patient relationship plays an important role for many oncologists in this regard, and communication skills are increasingly recognized for their importance in this arena. We outline several clinical scenarios that pose particular challenges to oncologists. These include breaking bad news and the patient’s response to hearing bad news, transitions in care and offering end-of-life care, participation in investigational studies, error disclosure, complementary and alternative medicine, spirituality, family discussions, and cross-cultural issues. By highlighting the relevant psychosocial issues, we offer insight into, and tools for, an enriched dialogue between patient and oncologist. The doctor-patient relationship can be viewed as the ultimate buffer for dealing with the hassles encountered in clinical oncology.

Oncologists face a multitude of stresses in their daily clinical work. Like most physicians today, they are overburdened with paperwork, phone calls, and the stress of having to see too many patients in too little time. In addition to this aspect of clinical medicine in the current health-care climate, oncologists grapple with an element of psychological stress that relates to the suffering their patients experience. Although this stress may not be unique to oncology, it is profound. Each patient, from the moment a diagnosis of cancer is made (and often even before then), is in crisis. Each transition in care (recurrence of disease, progression of disease, failure to respond to treatment, and often inevitable end-of-life transitions) represents a new crisis. The oncologist is witness to frequent and repeated episodes of suffering by the patient and the family, and treats not only the biologic disease, but also the high levels of distress and pain that unfortunately accompany cancer. Many relationships with patients end in death. Impact of Stress on the Physician These stresses demand time, energy, and emotion, and oncologists answer this call. Physicians have been noted to represent a rather overachieving group, willing to place high demands on themselves with a tendency to work long hours, have perpetually higher performance expectations, and leave themselves little time for leisure. Physicians are not taught to slow down and are not encouraged to show signs of fatigue or grief. Physicians can be left feeling guilty about not having spent more time with their patients and the patient's families. Their sympathy for the patients' plight is great, and guilt over feelings of failure when they are unable to reverse this plight is high. In addition, these feelings may be particularly painful when the physician either identifies with the patient personally (ie, similar age) or is reminded of a family member who may have died. Personal factors add to the professional and emotional stress of oncology. Many physicians feel guilt over time not spent with their own family. This can be intensified in oncology: How does your child's soccer game compete with your patient's death? Who wins and who loses? Often, it is the oncologist who further sacrifices personal time in order to meet the professional demands on his or her time. Burnout These stresses can become overwhelming. The term "burnout" has been defined as occurring when work and/or other demands exceed the ability to cope, resulting in psychological distress and/or physical symptoms. A cross-sectional study of American Society of Clinical Oncology (ASCO) members found 51% acknowledged feelings of burnout. Maslach identified three components of burnout: (1) emotional exhaustion, from all the hassles and stresses encountered; (2) depersonalization, ie, a loss of empathy and feeling for patients and families; and (3) diminished sense of personal achievement and performance. These three components represent three important areas of function for physicians: maintaining emotional wellbeing, relatedness to others, and a sense of professional accomplishment. Most oncologists experience high levels of stress that can lead to emotional exhaustion. Depersonalization, while acting to diminish emotional distress, can...
become maladaptive. (The sense of accomplishment is diminished when one is no longer open to hearing patients' tragedies and triumphs, or no longer able to listen attentively and communicate in a supportive and comforting way.) Maintaining that sense of personal accomplishment is important to offset the stresses that might otherwise lead to emotional exhaustion and depersonalization. The majority of oncologists feel that their field is challenging but rewarding.[8,10,11] How then do oncologists survive? **Survival Kit** Holland has developed a "survival kit" for oncologists (personal communication, J.C. Holland, 2002). She stresses the importance of maintaining humor, as illustrated by the longrunning 1970s television series, *M*A*S*H*. Gallows humor has long been used by physicians to help relieve the tension of frequent encounters with death. She also stresses the importance of time away from work. She recommends protecting that time as much as time with patients, and honoring dates and schedules for leisure time as emphatically as work dates and schedules. Diet and exercise are equally important for physicians and for patients. In addition, the importance of monitoring ourselves as well as our colleagues for signs of burnout is critical. Early signs of burnout include emotional fatigue, loss of pleasure and enthusiasm for work, being easily irritated and annoyed with others at work and at home, or having physical symptoms that are found to have no physical origin (headache, arthralgias, anorexia or overeating, insomnia) and are likely stress related. Lastly, it is important to watch for dependence on alcohol or prescription drugs, which are occupational hazards for overstressed physicians. Of course, many of these issues are not unique to oncology, and there is a growing literature on physician coping. [1,12-17] **Communication** These global factors of stress exist in medicine in general, and in clinical oncology in particular. Some recurrent themes in clinical oncology are particularly stressful. It has been postulated that another way to reduce stress in clinical oncology is to improve communication.[7] A study by Ramirez and colleagues in the United Kingdom found that oncologists who expressed an inability to communicate with patients had greater stress and more symptoms of burnout.[11] A subsequent study confirmed that feeling insufficiently trained in communication skills was associated with less reported job satisfaction from relationships with patients, relatives, and staff.[18] This study concluded that improved communication could increase job satisfaction. Encounters and conversations that occur between patients and their oncologists require particular skill and attention to the patient's emotional needs.[19] The basic tools with which to initiate and conduct these discussions are rarely taught; yet, it is these very communication skills that cement the doctor-patient relationship and diminish stress for both. **Clinical Scenarios** Several difficult discussions are presented below, highlighting psychosocial issues from both the patient's and physician's perspective, with the goal of elucidating potential obstacles to communication and offering insight into ways to approach them. **Breaking Bad News** There is a growing literature on techniques for the delivery of bad news.[20-34] The Buckman and Baile mnemonic "SPIKES" is perhaps most commonly used.[35] In this model, the acronym SPIKES stands for set-up, perception, invitation, knowledge, emotions and empathy, strategy and summary. Set-up includes such details as turning off one's pager, having tissues available, sitting down, and making eye contact. Perception refers to the importance of asking patients for their perception of the illness prior to continuing the dialogue. Invitation refers to asking patients how much they want to know, and getting permission to disclose the bad news. Only after these steps have been taken should the information or knowledge be imparted. While it is important to empathize, it is equally important to resist the urge to jump in immediately in an attempt to "rescue" the patient. Rather, a remark such as, "This must be awful to hear," allows patients to explore and articulate their emotions. Lastly, the importance of summarizing and strategizing serves as reinforcement. Although these steps need not be followed sequentially or by rote, they offer a helpful model. The need to break bad news arises frequently in clinical oncology, whether discussing a new diagnosis, recurrent disease, progressive disease, or the lack of further chemotherapeutic options. Lesley Fallowfield and colleagues estimate that an oncologist breaks bad news thousands of times in his or her career.[36] Each transition in a patient's care that represents disease progression requires the delivery of even further bad news.[4] Patients often respond with questions like "What does this mean?" or "How long do I have?" One approach to these difficult questions is to resist the urge to answer immediately, and rather, to validate the importance of these questions, and to ask for further elucidation on any element that might be particularly upsetting. While one patient may be most scared of pain or suffering, another may be focused on attending a special event, such as a child's wedding or graduation. I want to answer your questions. But I want to make sure I understand what you're asking. Can you tell me a little bit more about what you're thinking right now? This must be very difficult. Eliciting this information serves to inform the physician of these important details, and communicates concern as well as continued commitment to the patient.[37] Before answering a
question such as "How long do I have?" it is crucial to determine the level of information the patient wants to hear. ("I need to know specifically how detailed the information you want to hear should be.") This prepares both the patient and the physician for the most sensitive delivery of information.

**Coping Styles**

Patients have a broad range of coping strategies, which they use to varying degrees at different points in their disease and with varying levels of success. Some patients withdraw; others become angry. ("How do you think I'm feeling, doc?!") Perhaps most difficult of all for the oncologist is the patient in denial. ("This doesn't mean anything, right?") Keeping the lines of communication open can be particularly important in these cases. Responses such as: "You seem angry," or "Tell me what this means to you and how you understand it," or "This must be very upsetting. Can you bear to tell me what you're thinking?" can help patients explore their emotions and reveal their fears, goals, and expectations. Exploring these issues helps to elucidate the facts, which in turn facilitates better coping. **Transitions in Care**

The level of stress (and distress) in patients is highest at transition points in treatment. Questions such as, "Isn't there anything more we can do? Why didn't that last treatment work? It's really bad now, isn't it?" reflect the painful process of understanding and dealing with the information. Here again, the oncologist has an opportunity to review with the patient what has happened, what decisions have been made, and what outcomes have transpired. This recounting of the patient's disease course serves to bring together the patient's and the oncologist's perspectives. Once this shared ground has been reached, there is the opportunity to inquire again into the patient's fears, goals, and expectations. The physician can then frame the next treatment plan in the context of the patient's goals and wishes—whether that may be further treatment, expectant observation, or supportive care. In the absence of such a conversation, the decision for expectant observation, for instance, can generate intense anxiety and doubt. "Shouldn't we be getting more tests? Are you giving up on me?" Questions such as these should prompt the oncologist to undertake a more detailed discussion, reframed in the context of the patient's disease state and goals. **End of Life**

End-of-life care is a field rich in literature and experience. The initiation of the discussion with the patient is something oncologists must do routinely, yet often feel uncomfortable doing.[38] Feelings of failure that the disease has progressed, as well as discomfort with the topic of death in general, are obstacles to the initiation of the discussion. When is the best time to initiate such a discussion? How does one start the dialogue? Again, eliciting patients' understanding of their illness and their wishes, and giving them a sense of control, are good starting strategies. As in any other transition in care, reviewing the patient's course (the "narrative") can be a useful tool in initiating the conversation. **Offering Comfort Care**

Three points of contention may pose particular difficulty to the oncologist. One such situation is that of offering comfort care. The patient may be thinking, "I don't want to give up," and the idea of "no further treatment options" may be frightening to both the patient and the oncologist. Often, it is easier to discuss nth-line chemotherapy or phase I trials (that may have exceedingly little likelihood of benefit) than the alternative of palliative care.[39] However, deferring the conversation robs both the patient and oncologist of an important opportunity to lay the foundation for future discussions. Remembering that word choice can make an important difference in these conversations, it is helpful to discuss end-of-life care in terms of "comfort care" rather than "withdrawal of care," with the emphasis on achieving maximal quality of life and freedom from distressing symptoms, especially pain. The obligation of the oncologist is to assure commitment to the patient's care and dignity, as well as the willingness to discuss the patient's concerns, whether they be personal, physical, emotional, or related to family issues. **Advance Directives**

Second, discussing advance directives, code status, or do not resuscitate (DNR) orders can be particularly difficult. Once again, when framing the conversation in the context of understanding the patient's goals and wishes, this discussion becomes easier. For example: I think it's important that I take the time now, while you're doing well and this is not an issue, to ask what you would want done if there ever came a time when you could not tell us yourself... That is, right now you are stable, and doing well. And I have no reason to think this might change any time soon. If, however, there ever came a time when something did happen, have you thought about what you would want done?... That is, if you were to suffer a catastrophic event, and your heart or breathing were to stop, have you given thought to what you would want done in this situation?... That is, would you want us to use machines to artificially resuscitate you?... Some people feel that in that situation, they would rather go in peace than to have so much done to them, when there would be so little likelihood that it would offer benefit for them. That is, we know that when patients have cancer and require those machines, the likelihood that they are able to ever leave the hospital is exceptionally slim. Have you
ever given thought to this matter?... Having heard what I've said, can you tell me what your thoughts are now? Reassurances that everything short of artificial resuscitation would still be done can be quite helpful. ("We would still do everything short of artificial resuscitation, but if we knew your wishes were to prioritize dignity and comfort, we could see to that.") When the patient's wishes have been elicited, the ability to frame this discussion in the context of goals and expectations is powerful and effective. That is, future treatment decisions become grounded in the context of the patient's stated goals, rather than the physician's assumptions. Although some oncologists fear disabusing their patients of hope, the conversation may actually reestablish trust and faith by reassuring that pain and distress will be treated aggressively.[38,40] This open communication may free the patient from undue anxiety and fear, and allow emotions to remain more positive and hopeful.

Physician-Assisted Suicide

Third, requests for physician-assisted suicide, while infrequent, can be difficult to handle. Regardless of the physician's personal or professional views on this topic, or the law in the state of practice, this request can serve as an important prompt for a renewed dialogue between the patient and physician. Such questions as "You seem to be thinking about death. Can you tell me what you've been thinking?" may open the door for communication. Regardless of the outcome of the discussion, the willingness to have the discussion, and the opportunity to gain insight into the patient's perspective and fears, sends an important message of concern to the patient. Many patients are relieved to be able to express these thoughts, and the conversation can highlight the need for an additional intervention to reduce a troublesome symptom or clarify an underappreciated conflict or concern. **Investigational Studies** Oncologists frequently enroll patients in investigational studies. From an oncologist's perspective, the idea of what to explain, and in what level of detail, is a daily dilemma.[39] The description of studies must be in language that is easily understood and devoid of technical terms.[19] Patients may respond with "I don't want to be a guinea pig" or "How experimental is this?" This represents another opportunity to "review the patient's narrative"-that is, to discuss the treatment history and review how or why an investigational study might fit into the patient's goals. For the patient who has already reached that point, or may be harboring the misconception that an investigational (phase I) trial will offer successful treatment for the disease, further discussion might still be necessary. Indeed, a recent study showed that patients have a more optimistic view of phase I and II protocols than do their oncologists.[39] A line as simple as "Tell me what you understand about this study" or "Tell me what's been explained to you about this so far" may help to correct any misunderstandings. In a study of why patients accepted treatment through investigative protocols, Penman and colleagues identified three factors: (1) "I thought it offered some hope," (2) "I trusted the doctor," and (3) "I was afraid of what would happen if I didn't accept it."[41] Patients felt the informed consent discussion was far less important than how the doctor presented the protocol and whether they were spoken to in a compassionate way. As a simple rule of practice, some clinical investigators make sure that hospice care is discussed as an alternative for all patients considering phase I trials in the metastatic setting. Some informed consent forms include mention of this alternative. This is one way of ensuring that discussions have included all options.

**Error Disclosure** Medical errors occur more often than previously recognized and far more commonly than is reported to patients.[42] Disclosure of errors traditionally has not been a part of medical education, although this is changing. Admitting when a mistake has been made can be difficult, emotional, and timeconsuming. Robert Buckman has developed an approach to this situation.[43] He advises full disclosure, which includes an explanation of how the error occurred, as well as the steps taken to prevent it from happening again in the future. He suggests that error disclosure is "breaking bad news without an invitation," since bad news must be delivered regardless of whether the patient or family wishes to hear it.[43] A warning remark, however, can serve to preface the discussion: "I have some serious news that I need to discuss with you." This approach may answer the patient's or family's question: "How could this have happened?" Buckman advises the physician to accept full responsibility for the error-"as your physician, I am ultimately responsible for every aspect of your care, and I take full responsibility for this situation." Efforts to keep the patient and family informed prospectively and in a timely manner keep the lines of communication open in such a difficult situation.

**Complementary or Alternative Medicine** It is estimated that at least 50% of patients use some form of alternative or complementary medicine.[44] Some physicians shrug it off, ignore it, or universally advise against such alternatives. Many patients firmly believe in the benevolence of vitamins, supplements, and herbs.[45] "They can't hurt me, right?" The lack of evidence to suggest benefit and growing concerns over risk make the recommendation of some alternatives difficult. Other complementary options such as touch, reflexology, massage, and acupuncture are benign and do seem to improve quality of life.[45] Perhaps most frustrating of all to
oncologists, is the acceptance by some patients of seemingly fraudulent or difficult-to-believe claims (especially from the Internet), such as "He's not a doctor, but he says he's cured people the doctors had given up on." Equally difficult to address are remarks such as "What have I got to lose?" This contention, however, can be seen as a model for negotiation in clinical encounters. It is important that the oncologist listen respectfully to any treatment strategy the patient has found or heard about and discuss it in appropriate medical terms, with attention to the potential benefits and risks.[46] A physician's unwillingness to engage in this dialogue represents a barrier to effective communication and ultimately damages the doctor-patient relationship. Spirituality The importance of spirituality to patients varies greatly. It may increase toward the end of life in some patients, particularly those who had relied on religion and spiritual beliefs earlier in life. A physician's ability to comfortably discuss such matters with patients can facilitate and enrich the doctor-patient relationship, regardless of the physician's religious beliefs or level of personal spirituality. For example, patients may ask, "Doc, do you believe in God? Will you pray for me? With me?" Whether the physician chooses to discuss his or her own beliefs, assessing their importance to the patient often opens a dialogue about the patient's sense of hope, community, and deeper meaning of life and death. While some view this as beyond the scope of an oncologist's domain, a growing body of literature confirms the importance of these issues in the patient's formulation of treatment plans and expectations of outcome.[47,48] Family Cancer at any age is difficult to accept. It affects not only individuals, but families as well. When they hear overwhelming news, patients frequently ask, "How do I tell my family? How do I tell my children?" Some oncologists speak with the family as well and assist in this difficult process. Cancer patients with young children are particularly poignant. However, most oncologists have not been trained in the understanding of how cancer affects a family and how it affects children. Paula Rauch suggests that failing to discuss how the children are dealing with a parent's cancer is to ignore a crucial and dramatic part of the patient's experience.[49] The lack of dialogue on this important topic can leave patients feeling overwhelmed and abandoned. Why do so few oncologists discuss these issues with their patients? Perhaps it is because they have not been taught to or do not have the tools to do so. Rauch teaches the "basics of child development" necessary to have this conversation with patients.[49] Understanding how a 2-year-old child conceptualizes and relates to the world, and how that differs in a child aged 7 or 17, helps guide a patient to useful approaches to talks with his or her children. Offering this insight to patients is another way of reinforcing the doctor-patient relationship. Cultural Diversity No matter where one lives or practices medicine, one encounters different cultures and beliefs about cancer and treatment. While this is an enjoyable aspect of interacting with people from different backgrounds, it can also be challenging. Wide distinctions between paternalism and autonomy in decision-making in American medicine compared to other societies can surface in clinical situations. For example, although there is strong adherence Cultural Diversity No matter where one lives or practices medicine, one encounters different cultures and beliefs about cancer and treatment. While this is an enjoyable aspect of interacting with people from different backgrounds, it can also be challenging. Wide distinctions between paternalism and autonomy in decision-making in American medicine compared to other societies can surface in clinical situations. For example, although there is strong adherence in the United States to the patient's right to autonomy and to withhold the diagnosis and information from the family, patients from other backgrounds may expect decisions about their illness and treatment to be made by their family, with differing degrees of their own involvement. "Don't tell my mother!" the patient's child sometimes insists. It may or may not be possible to honor this request, but again, it represents an opportunity for discussion, to learn more about a patient's and/or family's beliefs and expectations. In many cultures, the custom to withhold the diagnosis from the patient persists. A family from one of these cultures can pose a problem to the treating oncologist. Perhaps the easiest approach to this dilemma is to include the family in a discussion, where the physician asks the patient what he or she would like to know. Most families that don't want a loved one to be told about the diagnosis are acting out of a belief that the individual would not want to know. Few continue to request silence when the patient articulates a desire to know (or, more often, states that he or she has known all along but did not want to upset the family with such an admission). Moreover, when a patient does decline information, oncologists can easily respect the patient's request to discuss such matters with the family instead. Summary We have outlined several clinical scenarios that pose particular challenges to oncologists, with the goal of highlighting psychosocial issues from both the patient's and the physician's perspective. Our aim is to offer insight into, and tools for, an enhanced dialogue between patients and their oncologists. Increasing evidence suggests the importance of communication skills in establishing and maintaining a strong doctor-patient relationship, and it is the doctor-patient relationship that many oncologists perceive...
as the most rewarding aspect of clinical care.[11] Physician stress and burnout are receiving increased attention, as is the process of renewal. Holland's survival guide recommends the use of humor, protected time away from work (with family and by oneself), and attention to the level of stress and burnout in oneself and colleagues. Equally important is maintaining a forum for discussion of these issues. This forum tends to occur most naturally with colleagues in oncology, who understand and experience the same issues daily. The enrichment of the doctorpatient relationship, through good communication, can be viewed as the ultimate coping skill for dealing with the stresses encountered in clinical oncology.

Disclosures: The authors have no significant financial interest or other relationship with the manufacturers of any products or providers of any service mentioned in this article.

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