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Physician-Patient Communication in Cancer Care Settings

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Abstract: In Morocco, the topic of physician-patient communication in oncology still does not get the attention it deserves; doctors are familiar with the concept of healthcare communication in general, but the majority do not realize how important it is to focus on communicating with cancer patients. In this sense, this study targeted the oncologists working in the oncology hospital of the CHU Hassan II of Fez and attempted to explore some elements such as: the seniority, their knowledge about cancer communication (for instance: announcing the diagnosis, types of bad news delivered, dealing with patients' personal matters …), highlighting the communication obstacles encountered in cancer care, and finishing up with the physicians' suggestions to improve the communication quality in the cited oncology hospital. Oncologists working in both oncology and radiotherapy departments were given a self-completed questionnaire to fill up. (For reason of clarity, the findings will be best presented in the 'Results' section below).
Keywords: Cancer; Physician-patient communication; Physician-patient relationship; Cancer Communication.

INTRODUCTION

Health policies all around the world emphasize on the need for an effective communication between physicians and patients, and when it comes to cancer care, this need gets more serious. Cancer patients are very special in terms of communication: they have a disease that is considered – or stereotyped – as: incurable, very exhausting, and leading slowly to death.

As it is the case in several countries all around the world, in third world countries -such as Morocco - cancer is stigmatized and associated to stereotypes such as: surgery can only make things worse, it is a disease that is shameful to talk about, and so forth. In fact, communication breakdowns occur in every context of people's daily lives, and in oncology settings, these breakdowns can decrease the effectiveness of the physician-patient communication; as mentioned in 'Communication skills training for health care professionals working with cancer patients, their families and/or carers', an ineffective communication has negative effects for both patients and physicians [1]. For patients, the consequences are mainly the bad compliance with the treatment options, high levels of anxiety and dissatisfaction with the care, and low rate of recovery. For physicians, the impacts could be: an increase of stress and less job satisfaction, as well as risks of emotional burnout. In addition, in *"*Improving Communication with cancer patients*"* [2], P. Maguire provided a distinction between two types of barriers: patient-led barriers, such as: psychological disorders, fear of showing feelings … and professional-led barriers, like: fear of patients' emotional flood, lack of communication skills… etc. Overall, this study was conducted in the oncology hospital of the University Health Centre (CHU Hassan II) of Fez, Morocco, with the objective to explore the behaviours of the physicians (working in both the oncology and radiotherapy departments) towards their communication with cancer patients being managed in the cited oncology hospital.

Aim of the study

Essentially, the specific objectives of this study are:

- Assessing the physicians' knowledge about health communication in general, and cancer communication in particular;
- Finding out the way patients receive the diagnosis;
- Gathering the terms used to refer to "cancer";
- Exploring how oncologists deal with the patient's family when they decide to hide serious information (from the patient);
- Depicting the communication obstacles encountered by oncologists, and
- Gathering their suggestions to improve the quality of their communication with the patients.

METHODS

In social sciences, and especially in healthcare research, a survey is a commonly used research design to investigate several topics, and indeed for this study, we used questionnaires as instruments for data collection. It is a cross-sectional study that was carried out from July to August 2016. Also, we adopted a random sampling (a probability sample) including the 45 oncologists working in the Oncology hospital of the CHU Hassan II of Fez. These physicians were given a self-administered semi-structured questionnaire (containing three types of questions: close-ended, open-ended, and contingency). Moreover, the questionnaire was pilot-tested on 10 oncologists (out of 45), which allowed us to make the necessary modifications to make it as clear and efficient as possible. Generally, the questionnaire was designed to gather: the physicians' demographic data, seniority, knowledge or training in terms of communication with (cancer) patients, diagnosis announcement, bad news delivery, influence of patients' social-economic level on communication, dealing with patients' personal matters, communication obstacles, and finally the suggestions of physicians to improve the effectiveness of communication with their patients. Also, the first page of the questionnaire included a covering letter explaining: the institution of research, the confidentiality of the data being gathered, the authorisation of the director of the CHU Hassan II hospital, and at the bottom of the page, we thanked the participants in advance for their precious help. In general, the statistical analysis was conducted using SPSS v.20 software; the qualitative characteristics were described using frequencies and the quantitative ones were described in summary measures (mean and standard deviation).

RESULTS

The average age of the 38 participants was 25.4 (ranging from 26 to 38 years old); there were 32 residents, 3 oncology specialists and 3 professors, and their seniority in the oncology practice varied between 1 and 132 months. Surprisingly, only 9 (23.7%) of them have received training in communication with patients; 27 (71.1%) claimed that they don't announce the diagnosis, since the patients come to the oncology consultation being aware of their disease; other than the word "cancer", 12 (31.6%) use 'malignant illness' while talking to their patients and their families; 35 physicians (92.1%) assumed that they ensure the psychological support themselves, without the assistance of a psychologist; all the physicians (100%) confirm that the patients attend the consultations with companions; when asked about their reactions if the family ever asks them to hide the diagnosis from the patient, 22 (57.9%) chose to describe the 'big picture' to the patient and avoid details, 16 (42.1%) respect the family's request, while only 1 of them (2.6%) would tell the truth anyway; 44.7% argued that the worst news to deliver is having an advanced cancer; 37 (97.4%) of them explain the treatment modalities to the patients; 37 physicians (97.4%) argued that the socio-economic level influences the physician-patient communication process; 22 (57.9%) claimed that the duration of consultations was 15 to 30min with ordinary cancer patients, and for the newly diagnosed ones (first consultations) it was 30 to 60min (according to 24 physicians /63.2%); when it comes to questions exchange in the consultations, all (100%) the physicians allow it; 31 (81.6%) sometimes hide information from their cancer patients, mainly to prevent disturbing their psychological status (48.1%); concerning the discussion of personal topics, only 29 of them (76.3%) do so in the consultations; another important aspect was: how do they want their relationship with the patients to be, where only 20 physicians (52.6%) wanted to know them 'deeply' more as individuals than patients, whilst the other 18 (47.4%) wanted to keep the relationship as 'professional' as possible; 73.7% of physicians ask for feedback at the end of consultations to assess patients' understanding; the obstacles to an effective communication were mainly the workload (55.3%); finally in the questionnaire, the physicians were asked to provide suggestions to improve the quality of communication with their cancer patient (which will be cited in the discussion part); the table below sums up the results gathered through the questionnaires.

		n	%
Gender :			
	Male	5	13.2
	Female	33	86.8
Age (years) :		25.54	Min=26 y Max=38 y
Grade :			
	Intern	0	
	Resident	32	84.2
	Specialist	3	7.9
	Professor	3	7.9
Seniority (in months) :		31	Min=1 Max=132
Cancer communication training :			
	Yes	9	23.7
	No	29	76.3
Announcing the diagnosis :			
	Done by the doctor	11	28.9
	Diagnosis had already been announced by another healthcare professional	27	71.1
Terms used other than 'cancer'/ سرطان :			
	Malignant illness/ Malignant Tumour/ (in Arabic :مرض خبيث)	12	31.6
	The aggressive disease / (المرض الخايب)	11	28.9
	Chronic disease/ مرض مزمن	3	7.9
	Mass / حبوبة / Node	11	28.9
	Neoplasia / ورم غير حميد	2	5.3
	"ذلك المرض" / 'that disease'	7	18.4
Psychological support of patients is insured by:			
	The assistance of a psychologist	3	7.9
	The physician him/herself	35	92.1
Presence of patients' companions in the consultation :			
	Yes	38	100
	No		
Reaction towards the family's request to hide the diagnosis			
	You tell the truth to the patient	1	2.6
	You respect the family's request	16	42.1
	You give a general idea to the patient (avoiding the details)	22	57.9
Type of bad news delivered :			
	A very advanced cancer	17	44.7
	Relapse	8	21.1
	Terminal phase/palliative care/end of life	12	31.6
	Ineffective treatment	1	2.6
Explaining the treatment modalities :			
	Yes	37	97.4
	No	1	2.6
Communication problems related to the socio-economic status :			
	Yes	37	97.4
	No	1	2.6
If Yes, how do you manage it :			
You simplify the information			
	Yes	26	68.4
	No	11	28.9
You narrow the information to the bare minimum			
	Yes	4	10.5

	No	33	86.8
You ask for the presence of a relative to make the task easier			
	Yes	19	50
	No	18	47.4
You ask for the social worker's help			
	Yes	3	7.9
	No	34	89.5
Average duration of the consultation:			
With a newly diagnosed patient			
	<15 min	0	
	15 to 30min	13	34.2
	30 to 60 min	24	63.2
	>60min	1	2.6
With 'old'/regular cancer patients			
	<15 min	15	39.5
	15 to 30min	22	57.9
	30 to 60 min	1	2.6
	>60min	0	
Allowing the questions' exchange :			
	Yes	38	100
	Sometimes		
	No		
If Yes, why ?: (26 participants responded)			
An important step in the cancer management process			
	Yes	4	10.5
	No	34	89.5
For a better compliance with the treatment			
	Yes	6	15.8
	No	32	84.2
To evaluate the patients' information			
	Yes	3	7.9
	No	35	92.1
Patients look for answers to feel relieved			
	Yes	7	18.4
	No	31	81.6
The patients have the right to know anything about the disease : treatment, side effects, prognosis …			
	Yes	14	36.8
	No	24	63.2
To gain their trust			
	Yes	4	10.5
	No	34	89.5
To involve them in their own management			
	Yes	3	7.9
	No	35	92.1
Withholding information from the patients :			
	Yes	31	81.6
	No	7	18.4
If Yes, why ?			
	To provide them with hope	4	14.8
	To avoid disturbing their psychological status	13	48.1
	When the psychological status doesn't allow that	7	25.9
	When some information can induce the rejection of the treatment	3	11.1
	When the family requests so	0	

Asking for feedback at the end of consultations:			
	Yes	28	73.7
	No	10	26.3
If Yes, why ?			
	To evaluate the quality of care	8	21.1
	To assess the patients' knowledge	10	26.3
	To evaluate your own communication skills		
	(No answer)	20	52.6
Talking about patients' personal matters:			
	Yes	29	76.3
	No	9	23.7
If No, Why ?			
	This goes beyond my competence	1	16.7
	Avoiding anything not related to cancer management	2	33.3
	Being short of time	2	33.3
	To keep the physician-patient relationship professional	1	16.7
Nature of the physician-patient relationship:			
	Try to know them as 'individuals' and not as 'patients"	20	52.6
	Keep the relationship professional	18	47.4
Barriers to effective communication			
	Socio-cultural diversity	20	52.6
	Time shortage	20	52.6
	Work load	21	55.3
	Lack of communication skills	10	26.3

DISCUSSION

From the findings, we can notice that the average age of the physicians was 25.54 (ranging from 26 to 38 years old), which represents a young generation of oncologists working in the oncology hospital of the CHU Hassan II of Fez, and among the respondent participants, we found: 3 professors, 3 specialists, and 32 residents, with a seniority from 1 to 132 months in the practice, and the important number of residents reflects the interest that oncology and radiotherapy are gaining in Morocco, and especially in the CHU Hassan II. In fact, one of the definitions of health communication has been provided by Richard K Thomas: *"...*encompasses the study and use of communication strategies to inform and influence individual and community decision*"*[3], and in the questionnaires, the participants provided 26 definitions (out of 38 respondents),and most of them defined health communication referring to the "physician-patient communication in cancer care", or more generally "the communication between healthcare professionals and patients in health settings". Once asked about physician-patient communication training (and especially: cancer communication), only 9 have received it, which shows that there is a lack of communication skills trainings in this field. Concerning the diagnosis announcement, which is a critical step in the caner management for both parties (physicians and patients), most of the physicians (71.1%) claimed that they don't announce it, since the patients come to the consultations being already told by another health professional (referring physicians, a radiologist …). Plus, to avoid spelling the word 'cancer' - which might seem a little shocking- while talking to their patients, 31.6% of the respondents claimed that they use the term "malignant disease", 28.9% use both "aggressive disease" and "mass/node", 18.4% refer to cancer using 'That disease' - in Arabic: 'ذلك المرض' – (in the Moroccan context, 'that disease' refers automatically to the one and only 'cancer', which sometimes shameful to pronounce in public), and only 5.3% of them (2 physicians) use the term 'Neoplasia', being specific to the scientific jargon. The presence of a psychologist is not permanent during oncology consultations, and the findings showed that 92.1% of physicians handle the psychological support – for the patients - by themselves. In addition, the presence of companions with the patients looks very important, since all the 38 physicians claimed that their patients often attend the consultations accompanied by someone, either a family member or a friend. Besides, the delivery of bad news is an essential component of cancer communication, and the majority of the questioned physicians (44.7%) found that telling their patients that they have an advanced cancer is the hardest news to announce, 31.6% thought that talking about palliative care is hard to deliver, while only 2.6% of them found that announcing an effective treatment is difficult. In fact, discussing the disease (current physical status, treatment and its side effects, prognosis …) is mandatory, yet the patients' involvement in the cancer management differs [4, 5]; hence, almost all

physicians (97.4%) discuss the treatment options with their patients. Since Morocco is a third world country, and the number of illiterate people in Morocco (according to the ANLCA:Agence Nationale de Lutte Contre l'Analphabétisme) was about 10 million by the end of 2015[6], 97.4% of the participants saw that the socio-economic level influences significantly the communication process, from whom 26% tend to simplify the information to make the patients understand. Moreover, although the huge workload in this hospital, 63.2% of the participants mentioned that they spend 30 to 60 minutes *with a newly diagnosed patient*, and 57.9% of them spend 15 to 30 min with a regular patient (a patient who was previously diagnosed and already familiar with the health institution as well as the treatment modalities), which proves that the first consultations are given much time and attention to explain the situation and to introduce the patient to the protocols of cancer management s/he will undergo later. Communication in cancer care (as in human communication in general) should be bi-directional, as argued by J.F Smyth: "Talking and listening are the key skills that must be fine-tuned by everyone Talking involved in cancer management*"*[7], this is why 100% of the questioned physicians permit the questions exchange during consultations, and according to the findings, this is justified by the fact that the patients have the right to know about the details of care, also because this makes them feel secured and relieved. Sometimes, physicians withhold information from their cancer patients, and the results showed that 81.6% of the participants do so, and 48.1% of the latter argued that it is mainly to avoid disturbing the psychological status of these patients who can't handle too much (specific) information. Also, to ensure that communication is effective, 73.7% of the respondents claimed that they ask for feedback at the end of consultations. When it comes to discussing personal matters, 76.3% noted that they do it, while the other 23.7% don't, because they try to avoid anything that isn't cancer-related; this can explain why 47.4% of physicians try to keep the physician-patient relationship mainly professional, whilst 52.6% tend to know well their patients as 'individuals' and not only as 'patients', which makes the patients feel at ease, reduces their anxiety level and improves their satisfaction with care [5]. Then, when asked about the barriers to effective communication, 52.6% of the respondents indicated that the socio-cultural diversity and time shortage are the main obstacles, while 55.3% mentioned the workload, and only 26.3% assumed that the lack of communication skills is an essential communication barrier as well. Finally, the participants provided some suggestions to improve the quality of communication with cancer patients, which are presented as follows:

- Decreasing workload and dedicating more time to the consultations;
- Improving the work conditions (by providing individual offices to ensure privacy and minimize disturbances);
- A permanent presence of a social worker, as well as a psychologist in the hospital (or more preferably: an onco-psychologist);
- Training in terms of physician-patient, and mainly: cancer communication;
- Health literacy/cancer literacy education programs for patients;
- Print materials for low-literate patients and their family members, explaining the steps of the treatments and the side-effects;
- Bearing in mind that we deal with 'humans' not 'diseases' or 'medical records'.

CONCLUSION

Several policies are taking place to improve the quality of cancer care in Morocco, and communication and the human side of medicine should be part of it; in this study, we have tried to explore the physicians' behaviours related to communicating with their cancer patients in the oncology hospital of the CHU Hassan II of Fez, Morocco. The findings highlighted mainly: a low rate of communication trainings, lack of psychological support (by expert psychologists) for the patients, and the influence of the socio-economic level of patients on the communication process in particular, and on cancer management in general. At last, we collected the participants' suggestions for an effective communication, which might lead us – in the near future - to draft some 'How to' sections for dealing with specific communication needs for both physicians and patients.

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