

Listening to Cancer Patients' Narratives During Residency: A Pilot Study on a Communication Skills' Workshop Involving Patients-Partners

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Abstract

The field of cancer care still lacks best practices in communication. Few postgraduate training programs offer formal training to develop such skills. The patient partnership has been used in medical education to increase the sensitivity of the subjective experiences of patients. In our Canadian center, residents and patient-partners participated in an educational workshop on communication focusing on patient's narrative. The aim of this pilot qualitative study was to explore the experiences of participants in the workshop. Using theoretical sampling, we recruited 6 residents and 6 patient-partners. Semi-structured interviews were conducted and transcribed. A thematic analysis was performed. From analysis, 4 themes emerged: (1) lack of communication skills training; (2) barriers to effective communication in cancer care; (3) the empathy of patient-partners towards the communication challenges faced by residents; and (4) the participants' reactions to the workshop. Based on our findings, our communication skills workshop centered on narrative medicine and involving patient-partners appears feasible. Future research could study its pedagogical value and the optimal learning environment required.

Keywords

illness narrative, medical education, communication, cancer care, patient-partner, McGill Illness Narrative Interview, post-graduate training, patient engagement

Key Points

1. Six residents and 6 patient-partners participated in an educational workshop on communication skills using the McGill Illness Narrative Interview questionnaire to highlight the illness narratives of cancer patients.
2. Our pilot qualitative study revealed from analysis 4 emerging common themes: Lack of communication skills training for physicians, barriers to effective communication in cancer care, the empathy of patient-partners towards the communication challenges faced by residents, and the participants' reactions to the workshop.
3. Based on our results, we wondered if protected "emotionally safe" settings for communication training in cancer care should be explored in further research.

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4. Our pilot communication skills workshop based on narrative medicine involving patient-partners appear feasible, but its pedagogical value warrants future investigation.

Introduction

Caring for patients with cancer requires advanced relational and humanistic skills. These patients are in fact considered vulnerable to unmet needs and high levels of distress.^{1,2} Communication and personal support preferences are essential when providing care to cancer patients.³ Through their care trajectory, patients value their physicians as important sources of support. Outcomes associated with the quality of the physician-patient relationship have been extensively studied.⁴ Despite recommendations calling for cancer care specialists to learn advanced communication skills, patients still complain of shortcomings in this regard.⁵ According to recent data, physicians need to improve their ability to deliver bad news and address patients' needs.⁶

Effective communication between patients and physicians has been associated with beneficial outcomes such as increased safety, optimal adherence, fewer malpractice lawsuits, reduced physician burnout, and a better patient experience.⁷ Promising communication skills training programs are emerging,⁸⁻¹⁰ but rarely address subjective experiences of illness, instead focusing mostly on specific tasks.^{9,11-14} Whether their effects are sustained over time needs further research.¹⁵ During postgraduate training, very few programs teach advanced communication skills. They often fail to address psychosocial dimensions¹⁶ and lack curriculum structure, focus, and standardization.⁷ Residents themselves have reported little training.^{17,18}

Understanding the patient's illness narrative is the starting point of every effective communication and therapeutic relationship.¹⁹ Listening to life narrative in palliative care settings has been reported to have a pedagogical value for residents.²⁰ Sharing stories also seems to improve reflective ability, empathy and relationship-building.^{16,21}

Based on these data, our research team created a workshop on communication skills designed for residents in cancer care specialties. The workshop aimed to sensitize residents to the subjective experience of illness and treatment through their narrative. It was inspired by the patient partnership approach that has been used in medical education that involves real patients' testimony.²²⁻²⁴ The aim of our pilot qualitative study was to explore the experience of this workshop participants. The authors present this article in accordance with the COnsolidated criteria for REporting Qualitative research Checklist (COREQ).²⁵ (see Annexe 1).

Method

This pilot qualitative study was based on a phenomenological framework²⁶ and was approved by local research ethics

committee (CE 14.236). The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). All participants signed a consent form. Confidential support was offered to all participants when needed.

Sampling was purposive as the recruitment was relevant to our research question.²⁷ All residents were contacted by their residency program director. Cancer patient-partners were recruited and had been trained by the university. In accordance with patient partnership culture,²³ patient-partners were involved in every step.

We created an educational workshop on communication-based on the narrative medicine approach.^{28,29} During that workshop, residents were asked to use the McGill Illness Narrative Interview (MINI) scale to guide their 30 to 60 min conversation with a patient-partner. The MINI aims to collect illness narratives and was used in several medical fields and for communication skills training.³⁰⁻³² Two non-participant researchers silently observed each conversation.

Data were collected through a 45-60 min individual interview aimed to explore how they experienced the workshop. Our questionnaire was semistructured and inspired from previous literature²⁰ (see Table 1). Interviews were audio recorded and transcribed. The data was then coded as a whole, considering that patient-partners have the same value as healthcare professionals. A thematic content analysis was performed. Results were discussed with the research team and presented to the participants.

Results

Twelve participants were recruited for the study (n = 12), (6 residents and 6 patient-partners). Of these 6 patients, 4 participated in the workshop (2 of them participated twice for a total of 12 dyads). The other 2 participated only to the focus group (see Table 2 for their profile). Saturation was reached after 10 interviews. The next 2 interviews did not produce additional significant insights. From analysis, 4 themes were identified (see Table 3). All participants confirmed that the findings seemed relevant.

The first theme dealt with the lack of communication skills training for cancer care specialists. Most residents mentioned they had no role models for effective communication and had received no formal postgraduate training or inadequate one. One resident said it was hard to discern what was "clinically significant" as some said they found performing such interviews. Overall, most residents felt this workshop gave them an opportunity to hear patients' detailed descriptions of suboptimal medical encounters. They gave as examples inappropriate words used, nonverbal signs, or distractions (persistently looking at the computer screen, for example).

The second theme concerned the barriers to effective communication in clinical practice. All participants, both residents and patient-partners, noted several obstacles to optimal communication, such as lack of time and competing priorities. One resident estimated that exploring the patient's history was of lower priority than other tasks. Some patient-

Table 1. Questionnaires Used for Data Collection.

For residents	For patients partners
1. Is this like anything you already do or have seen done in your practice?	1. Have you ever had the opportunity before to share the information you gave today about your experience as a patient?
2. What more did you find out from this type of interview (as opposed to the usual clinical interview)?	2. Do you think the resident learned anything from their contact with you? If yes, what?
3. Is there any clinical value to knowing these additional elements of the patient's history?	3. Do you think your oncology specialists need to know all this additional information about your story to do their job well? What does your story have to do with other patients – what will the resident take away from it for their practice?
4. How do you feel about the experience of communicating with a patient-partner?	4. How was this experience for you? And for the resident?
5. Have you retained anything for your practice based on the patient's unique history?	5. Could you talk about the types of questions you were asked? Is the MINI a good questionnaire?
6. What sections were difficult for you? What sections were the most interesting?	6. When did you sense that the resident was most interested in what you were saying?
7. How do you think the patient felt about this interview with you?	7. Do you think this intervention could add something to the training regarding communication in oncology?
8. Tell me about the McGill Illness Narrative Interview (MINI) questionnaire.	8. Why isn't this done in clinical practice?
9. Why isn't this done in clinical practice?	9. Do you think there is a generational difference in communication styles?
10. How do you feel when a patient tells you about their bad experiences communicating with physicians? Is there a generational difference?	

Table 2. Participants' Profiles.

Residents (n = 6)	
Gender	Male: 1 Female: 5 Other: 0
Residency training level	First year: 1 Second year: 2 Third year: 1 Fourth year: 0 Fifth year: 2
Type of residency program	Radiation oncology: 3 Surgical oncology: 2 Medical oncology: 1
Patient-partners (n = 6)	
Gender	Male: 2 Female: 4 Other: 0
Age	Between 31 and 79 years
Tumour site	Lymphoma: 2 Thyroid: 1 Breast: 1 Prostate: 1 Blood: 1
Cancer severity	Nonmetastatic: 4 Metastatic: 2
Oncology treatments received	Chemotherapy: 3 Radiation therapy: 2 Surgery: 3 Hormone therapy: 1 Stem cell transplant: 1
Type of participation	Focus group: 2 Workshop: 4

partners revealed that listening to patients' stories might paradoxically cause residents to become desensitized to suffering, by a protective mechanism.

The third theme was about the empathy of the patient-partners toward residents' challenges in communicating. For example, one resident admitted having hesitated to address some sexuality issues related to cancer assuming that it would induce discomfort. However, the patient-partner perceived from nonverbal communication that the resident was a contrario avoiding this topic. Two researchers who witnessed the workshop observed expressions of empathy from patients-partners toward the residents.

The fourth theme focused on the reactions to the workshop. Patient-partners considered their participation as "therapeutic," as they could tell their story without any time pressure. Most residents recognized the workshop had a pedagogical value and believed it helped patients-partners to vent about previous difficult communication with physicians. However, some residents found it emotionally challenging, especially when addressing sexuality or spiritual issues. One resident reported being touched by the patient's story as it was a reminder of a loved one's experience. Although help was offered, the resident declined.

Discussion

To the best of our knowledge, this pilot study is the first to qualitatively explore the experiences of participants in a communication skills postgraduate workshop that involves patient-partners. Our findings appear consistent with previous data in medical education that revealed that engaging patient-partners during medical training raises the awareness of residents of patients' subjective experiences of illness. In fact, the patient partnership model is known to be based on the recognition of the patient's experiential knowledge built from living with a chronic disease.^{22,23} The workshop provided an opportunity

Table 3. Emerging themes and example of quotations used to support them.

Themes	Quotations	
	From residents	From patient-partners
Physicians' lack of communication skills training	<p>"It isn't only the questions that are different, but also the type of response that's different ... We don't really know how to manage this: do I <i>only</i> focus on the facts in the responses, or do I take in everything?"</p> <p>"We have certain training, such as discussing the levels of care ... but most of the training is things where we act. We have little training on what we do with the information we receive from the patient or how to interpret what we are told. I don't know what it means to be trained for that either"</p> <p>"But I don't think we have role models either, apart from certain exceptions ..., we don't have a lot of role models who teach a lot on aspects of psychosocial dimension ... Even if we are in oncology, it should be the case, but it is not necessarily the most favoured approach."</p>	<p>"The idea is that: the better you know your patient, the more you'll know what to say and when, and when to be quiet...."</p> <p>"I haven't had many doctors tell me that. Even the very nice ones. 'I'm listening ...' It's so simple!"</p>
Barriers to effective communication in cancer care	<p>"Given that we don't have much time, we focus more on things that are ... medical, physical ..."</p> <p>"I find it's rare that we have the time to really talk with the patient and look at different aspects of the disease and see how they are living with it. There are a lot of things that we don't realize that we don't pay attention to. It is never taught to us, never taught. We also don't realize the impact we have on what we say, on what we do, on what we release..."</p> <p>"I think there are a lot of people in medicine who don't have social skills ... I also think that there are doctors who are simply not interested in what the patient is going through."</p> <p>"In oncology, the more we know the patients, the more we can become attached to them. Then, if things don't go well for them ... we're going to be sad ..."</p>	<p>"I felt she was asking herself, 'Do I ask him? ... Maybe she was afraid of hurting me ... Because, when you talk about that... it brings back a lot of emotions."</p> <p>"Healthcare professionals, by dint of practicing in clinical settings, become desensitized. They do well because they can't always cry, they can't always be unhappy. They did the job to help. It makes them help. At some point, they can't take it anymore."</p>
Patient-partners' empathy toward residents' communication challenges	<p>"I think there's a part where she was very driven by wanting me to understand so I could be a better doctor, I felt she wanted to give me something that I could apply in the clinic."</p>	<p>"We sense it if they're checking to see if they've gone off their schedule ... The non-verbal says as much as ... what's said."</p> <p>"It's demanding to get to know the patient because it requires empathy.... If I hear a lot of stories over the course of a day ... I can become desensitized or become overly sensitive and then take it on myself...."</p> <p>"The part where it was most uncomfortable for me was when she brought up the question of the sexual dimension. I felt maybe she was embarrassed."</p>
Reactions to the workshop	<p>"In general, I enjoyed the experience very much. It's not something we're doing now in our course, but I think it's a privileged moment to be able to discuss so much with a patient partner and then really understand more about his experience as a patient through the course of his illness, both from diagnosis to convalescence."</p> <p>"It's rare that you have a complete story, from</p>	<p>"I'm also fascinated to see the impact it has on me ... Because it makes us reflect on ourselves."</p> <p>"First, to go through the whole story, I had done it for a long time. It got me a little emotional."</p> <p>"It does a lot of good to be heard. We need witnesses in life, I think. As it's quite a big experience, and it may not be over ... To have witnesses, who hear and who sympathize, it feels</p>

(continued)

Table 3. (continued).

Themes	Quotations	
	From residents	From patient-partners
	<p>beginning to end. I found it really interesting to see how each person experiences it differently. It was very interesting from a human point of view as a conversation.”</p> <p>“I find that I learned a lot of things in the listening.”</p> <p>“It’s more of a responsibility in the sense that we’ve been part of the experience with him, so we should listen, even if it’s not something that will be useful to us.”</p> <p>“To some extent, it takes us outside our comfort zone because we’re very automatic in how we do our interviews. That is, we adjust them to each patient, but still, we have a structure that we’ve incorporated since starting our residency.”</p>	<p>good.”</p> <p>“What I liked ... it’s not in the questionnaire, it’s the eye contact. Let her look at me and I look at her. Because there are a lot of messages going on there. You can tell if the other person is listening to you ... When someone is interested, you see it in their eyes.”</p>

Abbreviations: P, patient-partner; R, resident.

for residents to see patients not just as a set of symptoms, but as people with their own subjective reality.

Our results are consistent with the previous data indicating that good communication skills are lacking in medical practice.^{7,8,33,34} The residents mentioned during our pilot study having received no training to learn how to listen attentively, acknowledge the patient’s lived experience, or encourage emotional expression. They also mentioned not knowing how to identify what types of information being communicated were significant. Previous data indeed revealed that the need for both undergraduate and postgraduate communication training remains unmet³⁵ and has historically focused more on normative or measurable methods of physician–patient communication, such as delivering bad news.^{4,11} Our study might add a new perspective to that literature by highlighting the fact that being in contact with a subjective dimension might help future physician to be more competent in personalizing their approach. Programs designed to improve healthcare professionals’ communication skills could consider adding such workshop to their curriculum with the purpose to change the way they communicate with patients.

Surprisingly, we observed that some patient-partners expressed empathy toward residents. There is a possibility that patients-partners feel that residents are at risk of being emotionally disturbed by the patient’s suffering. The question of whether the resident who showed emotional discomfort after the workshop did not have yet the skills to maintain adequate emotional distance is unanswered. These observations made us wonder if communication training should require an “emotionally safe” setting for all healthcare professionals.

Limitations

The inductive nature of our pilot study prevents us from concluding that our workshop is efficient; a quantitative design

could better address this question. The small number of subjects (n = 12) limits generalization of the results. Furthermore, this study was conducted before the pandemic, raising questions about the applicability of its findings in the current context. The cancer journey has since been marked by disruptions in care and an increased reliance on telehealth.³⁶

Conclusion

This pilot study aimed to offer an understanding of the experiences of participants in a communication skills workshop involving patient-partners and focused on patients’ narratives. Our findings show that residents reported they had significant gaps in their training with regard to communication skills. Involving patient partners in such training could potentially be a powerful means for heightening the awareness of residents to human realities and subjective experiences. Future research is needed to answer whether such workshop could in fact help health care professionals become better at communicating with cancer patients, focussing on the whole person with consideration to human dimensions. Being able to listen to narratives might help clinicians to identify and better meet various needs of people with cancer, which encompass psychosocial, physical, sexual, spiritual, and existential needs.

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Supplemental Material

Supplemental material for this article is available online.

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