16 Communication Education in Oncology

Frank Vitinius, Isabel Hamm, Bernd Sonntag

> After all, harm can come from words, too, or from body language, not just from the tip of an errantly placed needle or a mishandled scalpel. Simulation isn't just for procedures anymore; patient-doctor encounters can be simulated too.
>
> LeBlanc 2015: 141

Abstract: In this chapter we present a brief overview of oncology communication training in education. The focus is on our own projects and on projects in which the Department of Psychosomatics and Psychotherapy at the University Hospital of Cologne was and is involved.

Good communication in oncology can only be taught to a limited extent through books; it requires regular practice. This chapter describes the various forms of communication trainings in the oncology setting, including KoMPASS training and the KoMPASS project (KoMPASS - "Communicative competence to improve the doctor-patient relationship

through structured training"). One focus is the use of role plays. We then describe the continuation of the KoMPASS project as training for doctors of all specialties at the University Hospital of Cologne (training program “Kommunikative Kompetenz”) and external doctors, the implementation of the program at the Robert Bosch Hospital in Stuttgart and the Cologne training course for advanced practitioners. Lectures, Balint Groups and verbal interventions in psychosomatic primary care, which are mandatory for some medical professional groups and voluntary for other doctors, represent a further teaching format. In § 43 on the topic of "Enhancing competence in oncology", we present various possibilities for evaluation.

16.1 Communication trainings

Doctors conduct a very high number of professional conversations in the course of their careers (see also § 1). On the other hand, training and further education in this area has so far been largely inadequate. International studies show that successful doctor-patient communication leads to a higher quality of life and satisfaction (Ford, Fallowfield, Lewis 1996, Loge, Kaasa, Hytten 1997), an improvement in psychological well-being (Fogarty et al. 1999) and greater adherence (Razavi et al. 2000) on the part of patients. In addition, participation increases the willingness to be included in a study (Wuensch et al. 2011). On the part of the medical profession, improved communication leads to greater professional satisfaction (Keller et al. in preparation) and more effective use of time (Boissy et al. 2016). The importance of high-quality communication is increasingly recognised in some institutions as well as at national level and the topic is being adopted in guidelines. For example, communication is a master goal of the University Hospital of Cologne for 2025. The National Cancer Plan calls for communication skills among healthcare professionals as well as multi-day training courses in this area (see § 43). Point 11.4 of the S3 guideline on psycho-oncology, which forms the basis for the certification of cancer centers, recommends that practitioners should take part in several days of training to improve their communication skills.

The following section 16.1.1 describes an oncology-specific training program in which the authors F.V. and B.S. are involved.

16.1.1 KoMPASS project

Concept

Oncology patients and their relatives are often under a great deal of stress and therefore confront doctors with difficult, emotionally stressful situations. Understandably, they place high demands on the communication skills of oncology doctors. It is of paramount importance to provide support and orientation to patients who are often unsettled by the diagnosis and treatment, and at the same time to establish a trusting relationship that is helpful in times of need.

To date, there have only been isolated, sometimes specialised approaches in Germany to prepare doctors for these tasks in communication training courses (Goelz et al. 2010, 2011; Vitinius et al. 2013).

Since 2008, KoMPASS Training as part of a study has offered a qualified and standardised training program with experienced trainers and specially trained actor patients at various locations in Germany. It is closely geared towards the concerns of participants working in oncology.

The training is aimed at doctors who want to become more confident in dealing with oncology patients, especially in difficult communication situations. Doctors with many years of professional practice and experience in communication training are also welcome, since they can benefit from the training as well.

The KoMPASS training promises the greatest possible benefit in terms of practical learning success and professional, time-saving even for experienced oncologists.

We have briefly summarised the background of the communication training in oncology elsewhere (Vitinius et al. 2013). Training programs should be designed to be learner-centered, i.e. oriented towards the concerns of the participants and additionally convey important aspects of communication in the sense of essential content with "communicative tools" (Stiefel et al., 2018; Stiefel et al., 2024).

The KoMPASS training program was developed with financial support from German Cancer Aid (principal investigator: PD Dr. Monika Keller, Heidelberg). The cooperation partners of Heidelberg from Leipzig, Nuremberg, Aachen/Düsseldorf/Gießen, Mainz, Cologne and initially Tübingen have met regularly for study meetings since 2007 and developed a concept for a training program for doctors working in oncology. Before the KoMPASS training courses began, the future trainers took part in a

train-the-trainer program in Basel with Langewitz and Kiss. Both Basel colleagues are very experienced in the field and are involved in the implementation of the Swiss mandatory training for oncologists. The oncologists in Switzerland themselves had expressed the preference to make such trainings obligatory. Since 2008, numerous communication training sessions have been conducted by the various trainers who are part of the KoMPASS study group, initially in the multicenter study and later also outside the study. There were at least two trained trainers per center. A total of 39 trainings were conducted in the context of the study: 2 trainings each in Tübingen and Mainz, 7 trainings in Heidelberg, 4 trainings in Nuremberg, 8 trainings in Cologne, 5 trainings in Aachen/Düsseldorf and 6 trainings in Leipzig. Additional training sessions were conducted by the trainer pairs outside of the aforementioned locations in Bremen (one training session by Heidelberg, four by Cologne). The KoMPASS training program and the follow-up training implemented in Cologne as "Communicative Competence" program is part of the EDCP-BRCA study, which offered women with pathogenic variants in the *BRCA1/2* genes decision coaching as support. In this study, the participating physicians were trained over several days. The nursing Decision Coaches received several days of training in the implementation of decision coaching with elements of our communication training (Stock et al. 2024). Two further studies involving F.V. use elements of communication training: 1) In the interdisciplinary EhyM-KUK project at Cologne University Hospital to improve hygiene measures (giving and receiving feedback, communication models) in the context of this practical, interprofessional training (). 2) In the GeMuKi study, which offers interdisciplinary health counseling for pregnant women and young parents, health care providers were also trained in communication skills. (Lorenz et al. 2021).

General conditions

General conditions: 10-12 participants per training course is an ideal number. Two experienced and competent trainers with field expertise in psychosomatics/psychotherapy as well as in the clinical field (e.g. many years of experience in psychosomatic consultation/liaison service and/or additional specialist in internal medicine) serve as facilitators of the process. Trainers are referred to as "facilitators". With two trainers, group work can then take place in small groups of 5-6 colleagues using

the individual role-play templates described below, the critical incident reports (CIRs, which we now refer to as "communicatively challenging situations"). The training, including the refresher session, comprises 26 teaching units of 45 minutes each: The basic training over 2.5 days and the refresher training after approx. 4-6 months). The basic training takes place on Thursdays from 5.30 to 8.45 pm, Fridays all day (9 am to 6 pm) and Saturdays from 9 am to 2 pm, depending on the center. The refresher session takes place on a Saturday from 9 am to 2 pm.

Process, content and teaching methods

The process that is followed in the KoMPASS training courses has been published in detail (Vitinius et al. 2013, Keller, Zwingmann 2012). The process is briefly outlined below: We start the training on the respective Thursday after a short round of introductions with the consecutive video recording of conversations of each participant with an actor patient. This standardised case is about the transmission of bad news (Breaking Bad News; BBN). At the same time, the other participants write down their own difficult cases in keywords. Subsequently, these cases are then worked on in small groups and the video recordings are viewed in excerpts, particularly with regard to successful "teachable moments", , but also with regard to conversation skills and strategies that need to be improved. Work in small groups of up to 6 participants alternates with work in the large group of up to 12 participants, in which the various interactive presentations with associated exercises on the four topics mentioned in the box (Box 16.1) take place. On Saturday, the group has developed good cohesion so that it can deal with the topic of death and dying and with the topic of mental hygiene/burnout prevention by means of various self-care exercises.

Box 16.1 Contents and methods of KoMPASS communication training

Practice-oriented knowledge transfer [4 blocks] on the topics:

- Basics of patient-centered communication
- Dealing with emotions
- Delivering bad news
- Dying and death in doctor-patient communication

Methods:

- Collecting doctors' own concerns using case studies [CIR]
- Role play (RP) [4 blocks]
- Small groups, 4-6 doctors per trainer, 1 actor
- Processing of the doctors' CIR, different role-play variants
- Structured feedback & reflection
- At the beginning of the training, explanatory talk according to script with actor patient [video recording], viewing and processing in small groups
- Topic-related exercises
- Reader with handouts & literature

Modified according to Vitinius 2013

The teaching methods used in the KoMPASS training include cognitive knowledge transfer, role plays, video feedback and structured feedback from colleagues and trainers. The content and methods of the KoMPASS training are summarised in Box 16.1.

The content includes topics such as "How do I conduct a helpful conversation?" This question relates to the foundations of doctors conducting conversations, conducting a conversation to convey information, conducting a conversation to convey a diagnosis as well as conducting conversations with relatives. Effective and resource-oriented use of time is taught. Special emphasis is placed on difficult conversational situations, such as breaking bad news and dealing with violent, aggressive emotions. So-called stumbling blocks in the doctor-patient relationship, such as a patient's mistrust or unrealistic expectations on the part of the doctor or patient, are addressed.

On the basis of this content, the topic of "dying and death" will be addressed on the third day of the course, as will the topics of self-care, burnout and mental hygiene.

In order to adequately convey the content, special methods are required that are tailored to adult learning. This includes incorporating the competence and the colleagues' own difficult clinical experiences into the training sessions, especially the role plays. The core elements of the training are the use of actor patients (ap), the processing of the participants' own cases (CIRs described in more detail below, see also Keller, Zwingmann 2012), the role plays (with and without ap) and the video recordings at the beginning of the training and at the start of the refresher session. Actors who have received training on how to give feedback in the patient role are used for the role plays.

The learner-centered perspective should be emphasised, including the participants' own cases, which are asked about at the beginning of the training and then worked on in role plays. Four theory modules with practical exercises are "Basics of conducting conversations", "Dealing with emotions" using the NURSE model (Box 16.2, Box 16.3), "Breaking bad news" (Box 16.4 and 16.5) using the SPIKES model (Baile et al. 2000) and "Dealing with dying and death".

Box 16.4a shows an example of a possible approach to delivering bad news that was discussed in the training.

Dealing with emotions is a central element of the training and the basis for delivering bad news. It is helpful to use the NURSE model (detailed description in § 20.4.6 and in the guidelines of the Ärztekammer Nordrhein (2023)), as well as taking on the role of the patient in the exercises, which enable doctors to become aware of feelings that they have previously paid little attention to in their everyday lives.

Box 16.2 Dealing with emotions (modified from the "Dealing with emotions" module of the KoMPASS training course)

N	Naming	Identify the emotion, name it as a suggestion
U	Understanding	To convey that one has roughly understood
R	Respecting	Convey that emotional response is appropriate
S	Supporting	Identify the patient's own resources, offer support
E	Exploring	Can you describe it to me in more detail, so that I can imagine it better?

Translation from Ärztekammer Nordrhein 2023: S. 31
(Further literature in chapter 20.4 of this Handbook)

Another approach to incorporating emotions is empathic statements, some of which can be very moving for both the doctor and the patient and strengthen the doctor-patient relationship if they are formulated authentically (Box 16.3).

Box 16.3 Examples of empathic statements
"We would all have liked the therapy to have worked for you."
"We would have wished you a different course of the disease."

Source: Examples of so-called "wish statements" from the train-the-trainer course of the KoMPASS working group in Heidelberg with Walter Baile 2015

Addressing potential feelings early on is also a component of the approach practiced by the Basel colleagues Kiss and Langewitz (personal communication in the train-the-trainer seminar) when giving bad news. This approach, described in Box 16.4.a, supports the patient's perception of the diagnosis and, initially, the processing of the diagnosis. It has an antidissociative effect, i.e. the patients are less mentally absent during the conversation, absorb more of it because the limited absorbtion-capacity is taken into account, and do not forget so much of the conversation. This leaves more time to talk appropriately about the patient's other wishes, such as information on therapy and support from various professional and private parties, instead of initially "overwhelming" the patient with information and thus only remaining at the factual level and to have the doctor speak too much compared to the patients.

Next to the BBN strategy, which is based on the procedure of the Basel colleagues Langewitz and Kiss, there are other strategies such as the use of so-called warning shots before the diagnosis is communicated: "Unfortunately, I have bad news for you."

Box 16.4a Positive example of "Breaking Bad News"
Doctor: "We are here today to talk about your diagnostic findings" (doctor pauses to wait for the patient's consent or for the patient to add to or suggest changes to the agenda). Patient nods, agrees verbally or suggests additions. Doctor: "Unfortunately, the tumor has increased in size" (doctor pauses until the patient reacts verbally and/or non-verbally, e.g. by averting his gaze, moving restlessly, changing his facial expression, crying, etc.) and then uses this as a basis to address a suspected emotion he perceives in the patient, without having to be exactly right). Doctor (example): "This is

very distressing/depressing for you now." (then a pause again so that the patient can comment, as the emotion can be corrected by the patient).
If the patient asks "What does that mean?" or "What do we do now?" after the doctor's statement ("Unfortunately, the tumor has..."), the patient is first informed in simple terms about a possible course of action (simultaneously determine the extent of the need for information).

Modified after Kiss and Langewitz, oral communication 2008

The procedure shown as an example in Box 16.4b is based on a CIR of a surgical colleague who had a guilty conscience after this conversation. He was able to successfully work through this sequence for himself during a training session (Keller, Zwingmann 2012).

Box 16.4b Example of an unfavorable approach to "Breaking Bad News"

Background: 19-year-old Turkish man, speaks German well. Enthusiastic soccer player in his home town. Prolonged swelling of the right thigh. Sample excision: locally extensive osteosarcoma, staging examinations without evidence of metastases

01 D You have a malignant tumor of the leg. The amputation of the leg is unavoidable.
02 P Then I'd rather be dead than give up my leg.
03 D (perplexed): I urgently need to go to the operating room (hands patient to a younger colleague).

Modified after Keller, Zwingmann 2012: 170-2

After the diagnosis is made, patients ask about the prognosis at different times and in different ways. In Box 16.5, we have shown a possible example in which we have deliberately refrained from giving exact dates because the prognosis cannot be predicted exactly in the early stages of the disease. In addition, there are also long-term survivors who were given a prognosis of a few months, but in some cases lived for 5-10 years after the prognosis interview.

Box 16.5 Dealing with the patient's question about the prognosis

Doctor: "Nobody can give you an exact prognosis (or "indication") about the expected progression. However, we are talking about months rather than years."

The results of the accompanying study (§ 43), which has now been completed, have been presented at conferences and are gradually being published. Vitinius et al. (2013) describe the high level of acceptance of the KoMPASS training by the participants. The cited article describes the concept, the implementation, the experiences with the training and the evaluation by the participants. In the following sections of this chapter, the topic of role-playing is discussed in more detail, as it is of paramount importance for the successful implementation of the training.

16.1.2 Making effective use of role plays

In view of the outstanding importance of role-playing in communication training, we will deal with this topic in more detail here. Due to the sometimes negative perception of the term "role-playing" by training participants, some European communication trainers such as Gulbrandsen have switched to using the term "exercises" instead. Alternatively, previous experiences with role-plays can be asked about in the introductory round and the concept of conducting role-plays with feedback rules should be explained. The Swiss colleagues talk at the beginning of their training sessions in the introductory round about the fact that most of the previous participants were afraid of role plays and video recordings at the beginning of the training, but at the end they said that they found role plays and video recordings to be the most helpful methods. We use three different types of role-plays in the training:

a. Filmed interaction as a doctor with an actor playing the role of a patient with advanced gastric carcinoma. The doctor's task is to appropriately communicate the tumor progression diagnosed in the current imaging and the associated termination of chemotherapy. This isa challenge even for oncologists with many years of experience.
b. Learner-centered role-plays with own cases (CIRs).
c. Role-plays as part of the lectures on "Dealing with emotions" and "Dealing with death and dying".

Role plays with own cases (CIRs)

The basis for the role plays (RP) of the participants' own cases are the CIRs (critical incident reports). The template of the CIRs is from the train-the-trainer with Langewitz and Kiss. The term CIR should not be misleading. They have no connection to error reporting in the military, fire department or hospital, but are role-play sketches by the participants of difficult communication situations that they have experienced, sometimes a long time ago. In Cologne, we now call the CIRs "communicatively challenging situation(s)". At the beginning of the training, the participants are asked to write down a situation in keywords on a form. The situation should be one that they remember as an unresolved or challenging situation in terms of communication, without having to present a "worst case scenario". They describe what they found difficult about the situation and about their behaviour. In addition, they write down the short dialog with the person they were talking to at the time. At the beginning of the training, the participants briefly present these CIRs, usually without directly discussing the cases in the introduction round. Instead, the trainers take up the cases in the small groups in order to implement them in role plays. Ideally, this approach leads to a clear experience of evidence for the protagonists in their changing roles as observers, especially as patients and/or doctors. Alternative procedures are developed together and made tangible. In this way, the cases are not only discussed, but the participants' own communicative repertoire is also expanded. Working with the CIRs is generally experienced by the participants as very relieving. Not only does the "playful" acquisition of new skills succeed, but also, in part, the reflection of one's own attitude with partially cathartic effects with the reduction of feelings of guilt and the questioning of one's own perfectionism. With Winnicott, one could say "sufficient is good enough".

The proportion of cognitive knowledge transfer in the training is kept low and is consistently linked to the performance of impromptu role plays, some of which are short and last between 1 and 5 minutes: two role-play sequences on the topic: "What happens if I ignore the emotions of the patient and of myself as a doctor?" and a role play with a patient in the palliative stage (ascites in peritoneal carcinomatosis). We sometimes use SP patients when it comes to emotionally expressive roles, but we also realise how important it is for doctors to have experienced themselves in the role of a patient. The impromptu role plays, which are

embedded in the lectures, are performed repeatedly, then reflected on together and played again.

Participants are generally very willing to take part in the various role plays, which are conducted in a relaxed atmosphere.

Feedback rules

In addition to this relaxed atmosphere, we believe that an appropriate feedback culture, which we introduce before the role-plays, is key to success. We describe the feedback rules and follow them ourselves. We ask what the participants liked about the role-play and what they can imagine as alternative or further behaviour. "Negative" criticism should be avoided and - if it is expressed – it is reformulated by the trainers together with the participants into a suggestion for potential behavioural change or it leads directly to another role play. We do not use a sandwich strategy (positive, then negative, then positive feedback at the end). We think that the "ingredients" for the sandwich may potentially be missing and furthermore consider this strategy to be too artificial. It seems much more important that the participants have new experiences, are able to reflect on them and internalise them, which is achieved with the help of the feedback strategy we use.

Sociodramatic techniques

New experiences for the participants are also made possible through the use of sociodramatic techniques (Baile et al. 2012, 2013). For example, the participants are asked to stand behind one of the seated protagonists of the role play and express feelings and thoughts that they assume the protagonists have in an "I" message. In addition, the protagonists can nod or shake their heads, depending on whether they perceive these feelings and thoughts. Another technique is role reversal, which is used to put oneself in the other role.

These enormously dynamic techniques accelerate the role-playing process and bring previously hidden content and feelings to light so that they can become visible to all participants and flow directly back into the actual role-playing. In addition, the use of sociodramatic techniques contributes to a high level of activity among the participants and better mentalisation of emotional processes.

Trainer role

The trainer's task is to moderate and facilitate the role-playing process. It is necessary for them to introduce the role-play rules as well as the time-out rule for the participants and for the trainers themselves: "You or I as the trainer can interrupt the role-play at any time." The interruptions are then used for short consultations in the whole group so that the RP can then continue under different conditions. It is extremely important that the RP participants receive an appropriate amount of feedback. Too little or too much feedback from the group is counterproductive. The trainers may well need to intervene to provide supplementary feedback or steer the group. Finally, the RP participants are given a "debriefing", e.g. in the following form: "What did you take away from the role-play today?"

16.1.3 Communication training - dates, variants and venues

Training courses will continue to be offered at various locations such as Leipzig, Heidelberg, Cologne and Bremen after the KoMPASS study has been completed. Nuremberg already offered a different training program for doctors before the study began. The strong commitment of the Bremen Cancer Society, which financially supports the implementation of the training courses for doctors in Bremen and Bremerhaven, should be emphasised. These training courses are organised jointly with the Bremen Medical Association. The KoMPASS trainer group also offers in-house training, for example in Chemnitz, Hamburg and for colleagues in Krefeld. Furthermore, individual training courses for nursing staff or entire teams have also been completed in a large cardiology department and a palliative care clinic, among others.

Due to time and financial constraints of the participating institutions, we have also carried out some shorter training sessions in order to encourage participants' interest in the longer training sessions. We believe that it is better to have a one-day training to try it out than no training at all. Shorter training courses are also effective for specific learning objectives (Karger et al. 2022). In some cases, these training courses had a different focus than the medical communication training courses, e.g. at another large hospital in Cologne as a management course, in which, for example, staff appraisals were practised. Participa-

tion in these training courses was not compulsory for the participants. One exception of all trainings is a mandatory training course based on the KoMPASS training program in a non-oncology department of another university hospital, which was ordered by the hospital management due to a negative survey result from an external institute. The patients of this clinic had expressed dissatisfaction with the medical communication.

See section 16.2.2 for information on extending the training to other medical groups beyond oncology in the sense of "faculty development".

16.1.4 Overview of training concepts and programs

The question of how a training must be structured in order to be effective is of central importance. Information on this can be found in a meta-analysis by Barth and Lannen (2011) in relation to the topic of communication training in oncology. They found that longer training sessions have higher effect sizes than shorter training sessions. One or more refresher sessions or telephone counselling after the initial training increases the effect of the training.

Moore et al (2018) published a Cochrane Review on "Communication skills training for healthcare professionals working with people who have cancer". They conclude that various CST (Communications Skills Training) courses appear to be effective in improving communication skills such as information gathering or supportive skills. From their point of view, it is unclear whether refresher sessions are necessary and how long the effects of the training last.

Of particular note is the presentation by Fallowfield et al. (2002) published in Lancet, who demonstrated multiple effects of a three-day communication training course in the UK in a RCT, e.g. on the expression of empathy and appropriate response to the signals given by the patient. They concluded from their results that even experienced doctors do not solve communication problems over time or through clinical experience (Fallowfield et al. 2002).

In order to be able to carry out training courses successfully, qualified trainers are required who are trained in train-the-trainer seminars and then undergo continuous additional training (for web links, see further information: 16.3). The Cleveland Clinic has extensive experience in train-the-trainer programs. Train-the-trainer programs are also offered by the European Association for Communication in Health Care

(new term: International Association for Communication in Health Care).

At the European level, there was a consensus meeting on communication skills training. Recommendations regarding the setting, objectives and participants, content and pedagogical tools such as role plays, constructive feedback on participants' skills, organisation, outcome, additional objectives and research were addressed (Stiefel et al. 2010 and 2018). Here are a few examples of these: Regarding "content and pedagogical tools", role plays and constructive feedback related to participants' skills are listed. It is recommended to use validated outcome measures. In future, different training courses should be compared with each other (Stiefel et al. 2018).

In terms of organisation, training should be financed by the participants' employers (Karger et al. 2022).

There are successful models of training programs in various countries and institutions. In the USA, communication trainings have been implemented in clinics and cancer centers. At Memorial Sloan-Kettering Cancer Center, for example, 515 clinicians have completed training (Bylund et al. 2011). The program consists of nine different teaching modules. Participants in the program showed a significant increase in their communication with patients in various contexts.

Other well-known models are practiced in Houston by Walter Baile, who supervised and regularly trained the KoMPASS study group. He is also involved in the Oncotalk program (e.g. Back et al. 2009). The program's website (§ 16.4) includes instructional videos and sections for trainers and participants. One focus is on working with small groups. The Cleveland Clinic offers another comprehensive program (§ 1;). Kiss, who was working in Switzerland at the time, was instrumental in the development and implementation of the Swiss mandatory training for oncologists. The training consists of a basic training followed by 4-6 telephone counseling sessions and a follow-up session after 6 months. These training courses have been held for 20 years. In Basel, training programs are not only offered and researched for doctors, but also for nursing staff (Langewitz et al. 2010). In Germany, a 10-hour interprofessional communication training course for doctors and nursing staff was also evaluated at four cancer centers at the university hospitals in Aachen, Bonn, Cologne and Düsseldorf. This "KommRhein Interpro" study, funded by German Cancer Aid, compares the effectiveness of interprofessional training with training for doctors only and a control condition (information leaflet only). In addition to the perspective of the

caregivers, it also includes the perspective of the patients (Karger et al. 2022). Cancer patients were also involved in the development of the interprofessional communication training by recording the patients' perspective on the developed curriculum through semi-structured interviews (Ernstmann et al. 2022).

16.2 Dissemination / implementation in practice

To date, communication training for oncologists in Germany has only been offered as postgraduate voluntary training, but not yet as part of residency. "While much has already been achieved in the comprehensive and sustainable implementation of communication training in (medical) study, anchoring (mandatory) communication training in continuing medical education (CME) is still a major challenge." (Ärztekammer Nordrhein 2023, p. 104; brackets and the content of the brackets are from the authors of this chapter). One aim of the KoMPASS project is to implement the training courses in CME, as has already been done in Switzerland for another communication training course. There, participation in communication training is mandatory for oncologists. In the next section, we describe further steps regarding the continuation of the KoMPASS project.

The implementation of communication training from research into practice represents a difficult but important step. The KoMPASS project is partially in the phase of implementing scientifically investigated training in practice, comparable to phase IV according to Campbell et al. (2000) on the subject of complex interventions. In this model, in addition to a preclinical phase in which the evidence is reviewed, there is Phase I ("modelling"), Phase II ("exploratory trial") and Phase III as a "definitive randomised trial". Strictly speaking, Campbell refers to RCTs. The KoMPASS study is not an RCT but a controlled study. Phase IV ("long term implementation") represents the highest stage in this model.

In 2015, we implemented the "KommKomp" training courses (program “communicative competence”, in German “Kommunikative Kompetenz”), a version of the KoMPASS training courses at Cologne University Hospital, which no longer relates solely to the oncology setting, but to challenging communication in all clinical disciplines. With the support of the Medical Director, we have since held four training sessions per year for colleagues from all clinical disciplines. These training

courses are also open to colleagues from outside the hospital. In this book chapter, under 16.2.2, we present the preparations and advertising measures for this program in the sense of "faculty development" and report on initial experiences. Until now we have trained more than 500 physicians in KoMPASS and KommKomp trainings.

In Cologne, some KoMPASS participants wanted to take part in further training sessions after the refresher session. We therefore developed a training course for advanced participants outside of the KoMPASS study and have been offering this once a year with different content since 2011. During the Covid-19 pandemic, we paused these training sessions depending on the phase of the pandemic. We conducted the KommKomp training sessions partly in person and partly online if it was possible. We present the content and experiences with this advanced training under 16.2.1.

Another teaching format used by us (B.S. and F.V.) for conducting conversations with oncological and other patients was the lectures, balint groups and verbal interventions in psychosomatic primary care, which is mandatory for some medical professional groups such as gynecologists and general practitioners. It is completed voluntarily by other doctors, too. In addition to theoretical parts, we taught individual elements from the KoMPASS training such as delivering bad news with the participation of actor patients. To date, we have trained around 300 general practitioners and hospital doctors in psychosomatic primary care.

Other important steps towards dissemination include the presentation of the KoMPASS project on television and in the print media as well as the activities of the KoMPASS study group at congresses (see also § 43).

Of particular importance are efforts to recruit participants so that training courses are not canceled due to insufficient numbers of participants. Many clinics in Germany have problems recruiting enough doctors for communication training to take part in a training course lasting several days (Vens-Cappell et al. 2024, submitted). A recruitment and advertising strategy consisting of various components is required. Both top-down and bottom-up approaches are required.

With regard to the "Communicative Competence" project, the Medical Director of the university hospital supports us by giving a foreword in our advertising flyer and in a prominent position in the annual report of the clinic as a whole, which is an example of the top-down approach. He recommends that all medical staff take advantage of this opportunity

for professional and personal development. Another example is when a head physician encourages colleagues from their own clinic to take part in the training. An example of a bottom-up approach is when a junior doctor asks her head physician for in-house training and asks for appointment place in the KoMPASS study group.

So far, we have had particularly good experiences with directly approaching potentially interested parties. We also ask former participants to recommend the training to others as multipliers. In addition to sending out emails about the training program and announcing the training courses on the hospital's intranet and website, we distribute flyers to all clinically active medical staff at all of the university hospital's clinics and other hospitals. We also use various print media and television. Our colleagues working in the consultation and liaison service specifically address interested colleagues. In addition, FV presented the training program at public specialist congresses (internal medicine congresses, paediatricians' congresses, psychosomatic medicine congresses, etc.). We presented the training in internal meetings in the university hospital's clinics.

16.2.1 Training for advanced practitioners

In the advanced training courses, which take place once a year, we have reduced the amount of theory even further compared to the KoMPASS training. The basic elements of these training courses are

1. Feedback round: How have your experiences been since the last training? What has changed in relation to your patients/your profession?
2. Formulation of personal learning goals
3. Cases of the participants or analysis of their videos from practice/clinic
4. Role play with the participation of trainers: How do trainers proceed? Trainers as models in role play

In several advanced training sessions, one of the participants conducted an interview with a patient from our ward or from the hospital. The interview is followed by a feedback round involving all participants and the patients. The patients were each able to give an instructive description of how they experienced acute medical care in their own hospital

and in other institutions in terms of communication and what they would have liked differently in some cases. In addition to this communicative focus, the participants were able to familiarise themselves in individual training sessions with the diagnosis of post-traumatic stress disorder and its consequences in everyday clinical practice, such as the triggering of intrusions through seemingly banal medical procedures such as blood sampling and sonography.

The following is a brief description of the topics we have dealt with in the advanced training courses since 2011. In 2011, in addition to the aspects described above, new developments in psycho-oncology were presented in the training using the example of the "Managing Cancer and Living Meaningfully (CALM)" program (Nissim et al. 2012), following an internship by Bernd Sonntag at Gary Rodin, Toronto.

In 2012, instead of the article on CALM, we presented recommendations for dealing with different attachment characteristics of patients (Maunder, Hunter 2009). This was preceded by Frank Vitinius' participation in a workshop on attachment during the European Psychosomatic Conference in Denmark with Jon Hunter from Toronto. In addition to the four elements, this year we also addressed institutional problems regarding the implementation of successful physician patient communication: "Encouragement vs. inhibition by institution and individual: What keeps me from making important changes?" In our view, the so-called attrition effects of communication training can be partially attributed to the considerable demands placed on doctors in everyday clinical practice, whereby colleagues in private practice may have more creative freedom if they are their "own boss". Promotion by the institution occurs, for example, when directors themselves are convinced of the need for better communication and the associated training and therefore gradually enable their employees to participate in the training. Individual factors can be, for example, self-imposed excessive demands on themselves in the sense of a strict superego.

In 2013, Ms Lausberg, Head of the Department of Neurology, Psychosomatics and Psychiatry, Institute for Movement Therapy, Movement-oriented Prevention and Rehabilitation at the German Sport University Cologne, joined as a trainer and has since designed modules on the topic of "Introduction to the analysis of non-verbal behaviour - coding gestural behaviour" (Lausberg, Sloetjes 2009). This topic is discussed in detail elsewhere in this textbook (§ 12).

In the training, the participants also dealt with the topic of reducing their own stress by sharing bad news appropriately or increasing their

own stress by sharing it inadequately (Shaw et al. 2015). In addition, difficult interactions with relatives were addressed in role plays.

In the 4th training course, which took place in 2014, the proportion of exercises in the analysis of non-verbal behaviour was increased. The focus of this module was on gestural behaviour with role plays and exercises. Another topic was role-playing based on the participants' CIRs, including the topic of mistreatment ("You treated him wrong"). Our guest Gulbrandsen from Oslo, cooperation partner of the DFG-funded "CoTrain" communication training study (with F.V.), made a significant contribution: How do I communicate my own mistake or a mistake made by my own institution? Gulbrandsen also contributed a module, i.e. a double lesson, on the topic of "Shared decision making" (Gulbrandsen 2014). Another topic of the training was: How do I support colleagues in challenging situations?

In November 2015, we held the 5th training course. In addition to continuing the analysis of non-verbal behaviour with further reinforcement of the exercise component (focus on gestural behaviour with role plays and exercises), we have started to send out literature recommendations in advance, for example the reference to an article by Agledahl et al. (2011). This article refers to the issue that many doctors are "only" polite, but do not address existentially important topics. In the training, we then practiced addressing existentially important topics.

As a continuation of our practice-oriented reports from conferences and workshops, we looked at the topic of "risk communication" (Gigerenzer 2015). Employees of Gigerenzer (including the MPI for Human Development, Berlin) had been invited by F.V. to offer a workshop on this topic in Cologne a few months prior. As part of the advanced training, we reported on this and carried out some exercises. The exercises related, for example, to the assessment of the advantages and disadvantages of screening for the presence of breast cancer. The significance of the presentation of absolute and relative risks was discussed. A short presentation of the two-day "Four Habits Training" (German version "Co-Train") rounded off the program as a further element. The Four Habits are the following four key medical skills: 1) establishing a rapport with the patient, 2) eliciting the patient's perspective, 3) demonstrating empathic behaviour, 4) ending the consultation with information tailored to the patient and engaging in shared decision-making (Frankel, Stein 2001).

In December 2016, we increased the proportion of non-verbal behaviour to 6 units. The exact topic is: non-verbal interaction, in particular

gestures/touch and posture/position, with role plays and exercises. In addition, we gave specific recommendations for dealing appropriately with patients with insecure attachment patterns and practiced implementing the recommendations in role plays with an actor trained in this area. We also looked at the topic of "Difficult communication with employees": How do I have conversations with employees? What helps? What hurts? Participants again had the opportunity to bring their own difficult cases and videos of doctor-patient interactions and discuss them with us. Wolf Langewitz was a guest at further training sessions in 2017 and 2019, once on the topic of "information giving" and again on the topic of "Empathy - a difficult concept".

Overall, the advanced training has increasingly taken on the character of a lively workshop with guests, whereby we always take up wishes expressed by the participants before and during the training. Many participants have come regularly every year.

16.2.2 "Communicative competence" training program at University Hospital Cologne and Robert Bosch Hospital Stuttgart

The topics covered in KoMPASS training, such as communicating serious diagnoses, conflictual, emotionally stressful discussions, dealing with patients and relatives who are in denial or aggressive, and discussions about the termination of curative measures, pose major challenges for doctors of all specialties and all levels of training. For this reason, in the new "Communicative Competence" training program (), based on the KoMPASS training, we have expanded the circle of potential trainees to include all clinically active doctors at the university hospital and external colleagues since the beginning of 2015 and no longer limited participation to doctors working in oncology.

This makes us one of the first university hospitals in Germany to offer a professional training programme to optimise doctors' communication skills. The program has been permanently budgeted since 2018 and registration now takes place on the website of the education center ().

The KPAP project evaluates the possible long-term effects of communication training of the Cologne training program (see chapter 43). Following F.V.'s move to Stuttgart as head physician of the Department of Psychosomatic Medicine at the Robert Bosch Hospital in Stuttgart,

the training program was made possible there via the support association (“Förderverein”) and will become a permanent training. The aim is to offer the training to all newly appointed doctors. F.V. as a member of the Cologne faculty, B.S. after his retirement and possibly other trainers from the KoMPASS group and new trainers will continue to offer the training in Cologne.

16.3 Further information

Contributions on communication training are also made by members of the KoMPASS study group and the authors of this article as workshops or lectures at conferences. For example, two symposia were organised by the first author of this book chapter with the participation of Lausberg, Gulbrandsen and Baile at the ICCH conference in September 2016 in Heidelberg (), the 14th "International Conference on Communication in Healthcare" organised by EACH, and at the EAPM conference 2016 in Lulea (Sweden) with Keller and Langewitz.

Issue 06/2016 of the Rheinisches Ärzteblatt contains an article entitled "Many doctors don't know how much time even five minutes can be." The author of the article attended one of our training sessions and reported on it. In addition, the North Rhine Medical Association (2023) offers a free guide on the topic of "Communication in everyday medical practice". Further press articles can be found on the website of the Department of Psychosomatics and Psychotherapy at Cologne University Hospital. One of the authors of this book chapter was involved in the development of a training program for general practitioners (CoTrain, applicants: Wilm, Neugebauer, Pfaff, Vitinius, funded by the DFG). This is not an oncology-specific communication training course, but GPs will always treat oncology patients.

We hope that the national cancer plan will promote the further implementation of communication training in routine practice. Communicative competence must also increasingly be demonstrated as part of the certification of oncology centers. As a medium to long-term goal, we believe that communication training should be integrated into oncology and palliative care training curricula.

On our website you will find information and current dates for our training events and training program "Communicative Competence" (see

§ 16.2). Registration for the training is possible via the education center of the University Hospital Cologne.

Information on the training of trainers: Institute for Healthcare Communication (), the AACH FIT program () and the Cleveland Clinic program ().

Walter Baile with the Oncotalk program (e.g. Back et al. 2009), find more information on this website.

References

Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

Ärztekammer Nordrhein (2023): Kommunikation im medizinischen Alltag: Ein Leitfaden für die Praxis. Düsseldorf: Ärztekammer Nordrhein.

Agledahl KM, Gulbrandsen P, Førde R, Wifstad Å (2011): Courteous but not curious: how doctors' politeness masks their existential neglect. A qualitative study of video-recorded patient consultations. Journal of Medical Ethics 37(11):650-4.

Back AL, Arnold RM, Baile WF, Tulsky JA, Barley GE, Pea RD, Fryer-Edwards KA (2009): Faculty development to change the paradigm of communication skills teaching in oncology. Journal of Clinical Oncology 127 (7).

Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP (2000): SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist 5(4):302-11.

Baile WF, De Panfilis L, Tanzi S, Moroni M, Walters R, Biasco G (2012): Using sociodrama and psychodrama to teach communication in end-of-life care. Journal of Palliative Medicine 15(9):1006-10.

Baile WF, Walters R (2013): Applying sociodramatic methods in teaching transition to palliative care. Journal of Pain Symptom and Management 45(3):606-19.

Barth J, Lannen P (2011): Efficacy of communication skills training courses in oncology: a systematic review and meta-analysis. Annals of Oncology 22 (5), 1030-40.

Boissy A, Windover AK, Bokar D, Karafa M, Neuendorf K, Frankel RM, Merlino J, Rothberg MB (2016): Communication skills training for physicians improves patient satisfaction. Journal of General Internal Medicine 31 (7), 755-61.

Bylund CL, Brown RF, Bialer PA, Levin TT, Lubrano di Ciccone B, Kissane DW (2011): Developing and implementing an advanced communication training program in oncology at a comprehensive cancer center. Journal of Cancer Education 26 (4), 604-11.

Campbell M, Fitzpatrick R, Haines A, Kinmonth AL, Sandercock P, Spiegelhalter D, Tyrer P (2000): Framework for design and evaluation of complex interventions to improve health. British Medical Journal 21, 694-6.

Ernstmann N, Nakata H, Meurer L, Weiß J, Geiser F, Vitinius F, Petermann-Meyer A, Burgmer M, Sonntag B, Teufel M, Karger A (2022): Participative development and evaluation of a communication skills-training program for oncologists-patient perspectives on training content and teaching methods. Support Care Cancer 30(3):1957-1966.

Fallowfield L, Jenkins V, Farewell V, Saul J, Duffy A, Eves R (2002): Efficacy of a Cancer Research UK communication skills training model for oncologists: a randomised controlled trial. Lancet 23;359(9307):650-6.

Fogarty LA, Curbow BA, Wingard JR, McDonnell K, Somerfield MR (1999): Can 40 seconds of compassion reduce patient anxiety? Journal of Clinical Oncology 17(1):371-9.

Ford S, Fallowfield L, Lewis S (1996): Doctor–patient interactions in oncology. Social Science & Medicine 42(11): 1511–1519.

Frankel RM, Stein T (2001): Getting the most out of the clinical encounter: the four habits model. Journal of Medical Practice Management 16(4):184-91.

Gigerenzer G (2015): Towards a paradigm shift in cancer screening: informed citizens instead of greater participation. British Medical Journal 5;350:h 2175.

Goelz T, Wuensch A, Stubenrauch S, Bertz H, Wirsching M, Fritzsche K (2010): Addressing the transition from curative to palliative care: concept andacceptance of a specific communication skills training for physicians inoncology--COM-ON-p. Onkologie 33(1-2):65-9.

Goelz T, Wuensch A, Stubenrauch S et al. (2011): Specific training program improves oncologists' palliative care communication skills in a randomized controlled trial. Journal of Clinical Oncology 29:3402-7.

Gulbrandsen P, Dalby AM, Ofstad EH, Gerwing J (2014): Confusion in and about shared decision making in hospital outpatient encounters. Patient Education and Counseling 96(3):287-94.

Karger A, Bruns G, Petermann-Meyer A, Vitinius F, Wünsch A, Zimmermann T, Dinkel A (2022): Empfehlungen zur Umsetzung von Kommunikationstrainings an Onkologischen Zentren in Deutschland. Forum. 37(3):299-303.

Karger A, Petermann-Meyer A, Vitinius F, Geiser F, Kraus D, Ernsten L, Mayers AJ, Heuser C, Hiltrop K, Bremen R, Marx A, Ernstmann N (2022): Effectiveness of interprofessional communication skills training for oncology teams: study protocol for a three-arm cluster randomised trial (KommRhein Interpro). BMJ Open.

Keller M, Langendörfer F, Zwingmann J, Uhlmann L, Gärtner M, Brennfleck B, Barthel Y, Sonntag B, Vitinius F, Stein B, Gutberlet S, Söllner W, Petermann-Meyer A, Kruse J, Kuhnt S, Kiese M, Baile WF, Langewitz W (in Vorbereitung): Communication training enhances self-efficacy and work satisfaction of cancer physicians: a controlled multi-center study.

Keller M, Zwingmann J (2012): Kommunikation mit Krebskranken. In: Hax PM, Hax-Schoppenhorst T (Hg.) (2012): Kommunikation mit Patienten in der Chirurgie. Praxisempfehlungen für Ärzte aller operativen Fächer. Stuttgart: Kohlhammer, 166-177

Langewitz W, Heydrich L, Nübling M, Szirt L, Weber H, Grossman P (2010): Swiss Cancer League communication skills training programme for oncology nurses: an evaluation. Journal of Advanced Nursing 66(10):2266-77.

Lausberg H, Sloetjes H (2009): Coding gestural behavior with the NEUROGES—ELAN system. Behavior Research Method 41(3):841-9.

LeBlanc TW (2015): Communication skills training in the twenty-first century. AMA Journal of Ethics 17 (2), 140-3.

Loge JH, Kaasa S, Hytten K (1997): Disclosing the cancer diagnosis: the patients' experiences. European Journal of Cancer Prevention 33 (6), 878-82.

Lorenz L, Krebs F, Nawabi F, Senyel D, Alayli A, Bau AM, Stock S (2021): Perspektiven für die Implementierung des Innovationsfondsprojekt GeMuKi: Eine Querschnittserhebung der Einstellungen von Leistungserbringern zu einer präventiven Lebensstilberatung in den Schwangerschafts- und Kindervorsorgeuntersuchungen [Prospects for the implementation of the Innovation Fund project GeMuKi - a cross sectional study on attitudes of health care providers regarding preventive lifestyle counselling in routine prenatal visits and infant check-ups]. Z Evid Fortbild Qual Gesundhwes.

Maunder RG, Hunter JJ (2009): Assessing patterns of adult attachment in medical patients. General Hospital Psychiatry 31(2):123-30.

Moore PM, Rivera Mercado S, Grez Artigues M, Lawrie TA (2013): Communication skills training for healthcare professionals working with people who have cancer. The Cochrane Database of Systematic Reviews 3, CD003751.

Nissim R, Freeman E, Lo C, Zimmermann C, Gagliese L, Rydall A, Hales S, Rodin G (2012): Managing Cancer and Living Meaningfully (CALM): a qualitative study of a brief individual psychotherapy for individuals with advanced cancer. Palliative Medicine and Care 26(5):713-21.

Razavi D, Delvaux N, Marchal S et al. (2000): Testing health care professionals'communication skills: the usefulness of highly emotional standardized role-playing sessions with simulators. Psychooncology 9:293–302.

Shaw J, Brown R, Dunn S (2015): The impact of delivery style on doctors' experience of stress during simulated bad news consultations. Patient Education and Counseling 98(10):1255-9.

Stiefel F, Barth J, Bensing J, Fallowfield L, Jost L, Razavi D, Kiss A (2010): Communication skills training in oncology: a position paper based on a consensus meeting among European experts in 2009. Annals of Oncology 21 (2), 204-7.

Stiefel F, Kiss A, Salmon P, Peters S, Razavi D, Cervantes A, Margulies A, Bourquin C; participants (2018): Training in communication of oncology clinicians: a position paper based on the third consensus meeting among European experts in 2018. Ann Oncol.

Stiefel F, Bourquin C, Salmon P, Achtari Jeanneret L, Dauchy S, Ernstmann N, Grassi L, Libert Y, Vitinius F, Santini D, Ripamonti CI (2024): ESMO Guidelines Committee. Electronic address: clinicalguidelines@esmo.org. Communication and support of patients and caregivers in chronic cancer care: ESMO Clinical Practice Guideline. ESMO Open.

Stock S, Isselhard A, Shukri A, Kautz-Freimuth S, Redaèlli M, Berger-Höger B, Dikow N, Kiechle M, Köberlein-Neu J, Meisel C, Schmutzler R, Steckelberg A, van Mackelenbergh MT, Vitinius F, Wöckel A, Rhiem K (2024): Decision Coaching for Healthy Women With BRCA1/2 Pathogenic Variants. Dtsch Arztebl Int.

Vens-Cappell ER, Bergelt C, Jentschke E, Mumm F, Petermann-Meyer A, Vitinius F, Wünsch A, Albus C (2024, submitted): Implementation of communication skills training (CST) at oncology centers in Germany: results of a mixed-methods survey. Oncology Res Treat. 2024.

Vitinius F, Sonntag B, Barthel Y, Brennfleck B, Kuhnt S, Werner A, Schönefuß G, Petermann-Meyer A, Gutberlet S, Stein B, Söllner W, Kruse J, Keller M (2013): KoMPASS – Konzeption, Implementierung und Erfahrungen mit einem strukturierten Kommunikationstraining für onkologisch tätige Ärzte. Psychotherapie, Psychosomatik, Medizinische Psychologie 63 (12), 482-8.

Wuensch A, Goelz T, Bertz H, Wirsching M, Fritzsche K (2011): Disclosing information about randomised controlled trials in oncology: training concept

and evaluation of an individualised communication skills training for physicians COM-ON-rct. European Journal of Cancer Care (Engl) 20(5):570-6.

Citation note

Vitinius F, Hamm I, Sonntag B (2025): Communication Education in Oncology. In: Koerfer A, Albus C (eds.): Medical Communication Competence. Göttingen (Germany): Verlag für Gesprächsforschung.