43 Communication Evaluation in Oncology

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> "...I am more attentive, take more breaks, pay attention to the effect, take my time, pay attention to body language and react to it."
>
> Feedback from a participant after the KoMPASS training course

Abstract: In this chapter we present instruments for measuring communicative competence. They can be used in part to determine the effectiveness of communication training. In addition, we present didactic options with regard to expanding the competence of oncology physicians as trainees. Using the KoMPASS study as an example, the use of these instruments, the content of the training and the initial results of the evaluation of the training are presented. The effectiveness of such training is determined in a meta-analysis. In particular, sufficiently long communication training courses (at least 25 hours), with refresher sessions, have medium effects on communicative behavior.

43.1 Introduction

The National Cancer Plan identifies various fields of action. Field of action 4 is concerned with strengthening patient orientation. Goal 12a, which is located in this field of action, is directly related to the topic of our chapter.

Box 43.1 Goal 12a

All service providers working in oncological care have the necessary communication skills to deal appropriately with cancer patients and their relatives:

- The teaching of adequate communication skills is being improved in basic, further and advanced training for healthcare professions
- Communication skills are continuously reviewed and trained as part of quality assurance

Federal Ministry of Health 2016

Goal 13 is also related to the topic of our chapter.

Box 43.2 Goal 13

Patients are actively involved in the decision on medical measures:

- Provision of evidence-based patient information in the treatment process to support decision-making
- Practicing participatory decision-making (implementation of the "shared decision making" process)

Federal Ministry of Health 2016

In order to implement Goal 13, appropriate communication skills in the area of participatory decision-making are therefore also required.

The topic of "communicative competence" in oncology has thus been anchored in current health policy. This topic is relevant because it can guarantee a high level of medical quality and patient satisfaction (Lehmann et al. 2009). Despite its importance, communication in oncology can be extremely difficult and complex, as the patient's life is threatened by the cancer. Oncology patients must constantly deal with feelings of uncertainty and loss of control (Keller 2013). Other common is-

sues are the stigmatization and fear associated with cancer, as well as dealing with complex medical information. This adds a further emotional dimension to the communicative interaction between the treating physician and the patient (Arora 2003). In a study, D'Errico et al. (2000) identified the individual worries and concerns of oncology patients. These were be grouped into different areas:

- Health or illness
- Work
- Finances
- Religious or spiritual concerns
- Family and relatives
- Social and leisure activities
- Sexuality
- Self-esteem
- Existential worries

Patients often turn to their doctors with their worries and concerns, seeking social, personal and informational support, as well as assistance with difficult decision-making processes (Arora 2003). Fundamental to this is the need for respect, trust, hope and a sense of security (Keller 2013). If the doctor in charge is able to correctly identify a patient's worries, problems and specific concerns, he or she can actively support the patient in coping better psychologically with the illness and the associated treatment (Fallowfield et al. 2003).

Baile et al (2000) identified some of the issues that oncologists have the most difficulty with during a medical consultation:

- Stopping direct cancer treatment
- the transition to palliative care
- the possible occurrence of a recurrence

During the conversation, many doctors try to suppress their own intense emotions (e.g. feelings of helplessness, loss of control) and seem to be focused on themselves. This prevents them from focusing their attention on the patient and the task at hand. In order to protect themselves from too strong emotions, they switch to the factual level and avoid an emotional connection to the patient and their concerns, which then entails the risk of complete emotional separation and mutual depersonalization during the conversation.

The complex communicative demands and diverse stresses caused by fate of patients are noticeable in around a third of oncology doctors in the form of low job satisfaction, psychological stress and signs of burnout. In a study by Grundmann (2012), a burnout prevalence of 22-50% was found among oncologists. The prevalence of burnout can usually be predicted by an excessive clinical workload, which is often coupled with insufficient institutional support, such as supervision and team meetings about difficult cases, in order to cope adequately with patient contact. The consequences of burnout symptoms are increased job dissatisfaction, the risk of psychological morbidity, substance abuse and more frequent absences from work. Expanding skills in various areas such as reflecting on attitudes and one's own attitude, self-care and the appropriate use of communication skills can help to reduce one's own stress and increase satisfaction with one's job (see also § 43.4.1 of the KoMPASS study).

In addition to § 16 "Communication Education in Oncology", this chapter focuses on measuring the skills enhancement of the training and other forms of teaching described in § 16.

43.2 How do I measure skills development?

Various methods have been described in studies and reviews to measure patient satisfaction and their needs regarding the communication skills of the responsible physicians. For example, Dale et al. (2004) developed a valid and reliable rating scale to assess the importance of information needed by prostate cancer patients. Butow et al. (1996) developed a questionnaire to assess patients' experiences and preferences during a medical consultation. Furthermore, the questionnaire provides an opportunity to assess the advice given by the doctor regarding the treatment options he or she proposes. More specifically, Parker et al. (2001) assess patients' preference in the delivery of bad news, e.g. how they would like to be told serious, negative news about their cancer. To do this, patients have the opportunity to rate the contextual characteristics and content of the medical conversation, as well as the characteristics of the treating physician.

In order to support cancer patients in all these aspects, doctors need high communication skills, such as adequately delivering bad news, conveying complex information as easily as possible and supporting the

patient in making decisions. Furthermore, the doctors responsible must be able to react appropriately to intense emotions, anger, frustration and disappointment (Keller 2013). In a study by Messing (2007), the importance of the patient-centered methodological approach for well-functioning doctor-patient communication was demonstrated. In this approach, the attending physician takes into account the patient's perceptions, attitudes and needs during the medical consultation and adapts his or her behavior and communication techniques as the consultation progresses.

Appropriate communication skills include establishing a foundation of trust, gathering relevant information, addressing the patient's emotions, assisting with decisions related to health and the treatment plan, and initiating collaboration between the patient and family during the treatment period (Baile, Aaron 2005). Other points include focusing on an open-ended questioning technique especially at the beginning of the consultation, gathering information, identifying the patient's worries and concerns, using a patient-centered interview style, expressing empathy, listening attentively without interruption, and summarizing information at the end of the consultation (Fallowfield et al. 2003).

Good communicative behavior on the part of the doctor and adequate doctor-patient interaction seem to have a positive influence on the patient's health. Some positive aspects are:

- a lower level of mental morbidity
- a higher perceived quality of life
- a significant reduction in anxiety and depression

Furthermore, it also appears to have a positive effect on the healing process. The study by Arora (2003) showed that cancer patients who always received an adequate answer to their questions had a better psychological adjustment and better coping with their illness and the associated treatment in follow-up surveys. A study by Baile and Aaron (2005) showed that empathic communication with cancer patients and their relatives can have a positive influence on the course of the disease, particularly in the areas of quality of life, treatment satisfaction and dealing with treatment complications. Husson et al. (2011) showed positive correlations between the provision of appropriate information (e.g. how satisfied the patient is with the information received, meeting information needs, providing high quality conversation and clarity) and high physical, mental and global health-related quality of life. At the

same time, negative correlations were found between the provision of adequate information and the severity of anxiety and depression. In summary, these studies show that the better doctors can grasp a patient's situation after providing information, the more likely they are to help the patient cope with the cancer and reduce stress and negative emotions. This can lead to better mental health and lower levels of anxiety and depression.

Nevertheless, patients often report barriers that make it difficult for them to get the information they want. A frequently cited example is that doctors are often reluctant to provide patients with the full extent of information regarding their cancer, even though the majority of patients have a clear interest in receiving a lot of information (Husson et al. 2011). Here, doctors underestimate the patient's desire for information. In addition, doctors often use medical terminology that the patient does not understand, as in this case doctors overestimate the patient's understanding of specialist medical information. There may also be a lack of affective skills during the consultation, such as a caring attitude towards the patient, empathy and sensitivity (Arora 2003). Clinicians may miss opportunities to respond appropriately and empathically to patients, their concerns and worries, but rather discuss health-related issues and problems. On the other hand, some cancer patients find it difficult to retain the information they receive over time, which in turn results in a feeling of dissatisfaction with said information regarding their disease status or treatment goals. In most cases, they do not achieve the desired level of active participation in medical decision-making (Baile, Aaron 2005).

These findings make it clear that it is an important step to move away from the "one size fits all" method. An individualized approach is desirable here, taking into account both internal factors (a patient's needs, abilities, values, beliefs and emotions) as well as external factors and the environmental context in which the communication occurs (Hack et al. 2005). This point in particular requires evaluation tools that measure the doctor's level of communication skills in order to identify strengths as well as possible weaknesses, so that appropriately tailored training can lead to a targeted improvement in communication skills.

In their article, Orgel et al. (2010) describe the well-known discrepancy between self-assessment, knowledge and performance. Gulbrandsen et al. (2013) show as important effects of their training that this discrepancy between self-assessment and external assessment is reduced after 3-4 years, meaning that former participants in communica-

tion training assess themselves more realistically. In addition, existing skills cannot always be applied appropriately in everyday clinical practice, so that performance is suboptimal despite available skills. It should be emphasized that self-assessment as a measurement during training is not sufficient in itself. Similar to the assessment of adherence, we advocate a multi-method approach, also in the area of skills development discussed here.

In principle, the following measurements of the expansion of competencies can be carried out at a formal level, they can simultaneously serve to expand competencies:

Box 43.3 Measuring the expansion of skills

a. Self-assessment
- Orally
- Questionnaires

b. Assessment by actor-patients, patients, trainers and/or peers, i.e. by the participants of communication training in the role plays or in everyday life by colleagues:
- Verbal feedback
- Questionnaires

c. Video evaluation
- Feedback during the communication training in connection with joint viewing of the previously produced video
- Video evaluation (e.g. RIAS (Roter, Larson (2002))/DCAS)

Elsewhere in this textbook (Chapter 16), we describe the tools used in the KoMPASS study. Vitinius et al. (2013) describe the use of videos, role plays and feedback during the training sessions. These didactic methods of the learner-centered approach contribute to the expansion of competencies.

43.3 Overview of studies and articles on training evaluation

First, we look at four high-level evidence-based presentations: a Cochrane Review, a meta-analysis, the ESMO (European Society for Medical Oncology) guideline (Stiefel et al. (2024)) on the topic and the three-arm, cluster-randomized controlled multicenter study "KommRhein Interpro". Moore et al. (2018) come to the following conclusion in their Cochrane Review, where CST stands for "communication skills training" and HCP for "health care professionals":

Box 43.4 Effect of CST courses

"Various CST courses appear to be effective in improving HCP communication skills related to supportive skills and to help HCPs to be less likely to give facts only without individualizing their responses to the patient's emotions or offering support. We were unable to determine whether the effects of CST are sustained over time, whether consolidation sessions are necessary, and which types of CST programs are most likely to work. We found no evidence to support a beneficial effect of CST on HCP 'burnout', the mental or physical health and satisfaction of people with cancer."

Moore et al. 2018: p. 2

The ESMO guideline states that communication training improves certain behaviors of clinicians, such as their empathy and use of open-ended questions (Stiefel et al. 2024). However, the evidence on the long-term effects of training, patient satisfaction, anxiety reduction and clinician burnout is inconclusive. Research to date often lacks patient outcomes from clinical practice and a rigorous design, which limits the generalizability of results. Nevertheless, oncology clinicians who have undergone communication training tend to provide more empathetic and patient-centered care. Such training should go beyond the teaching of technical skills and should include the strengthening awareness of internal and external factors influencing communication as well as addressing relationship dynamics and emotional barriers to communication. Reflection on doctors' personal experiences that can affect their interaction with patients should also be integrated (Stiefel et al. 2024).

The three-arm, cluster-randomized controlled multicenter study "KommRhein Interpro" investigated the effectiveness of a 10-hour interprofessional communication training course for ward units at oncology centers of four university hospitals (Karger et al. 2022). A total of 30 ward teams were randomized into three study arms, in which the teams either received only written information or additionally the physicians of a ward received training or physicians and nurses of a ward received interprofessional training. Subsequently, hospitalized patients were interviewed about cancer-related anxiety at three measurement points within 3 months. The doctors and nurses were asked about the ward climate and workload before and after the training sessions. The results are currently being analyzed.

The effectiveness of communication training was confirmed in a meta-analysis by Barth and Lannen (2011). In particular, sufficiently long CSTs (communication training of at least 25 hours) have medium effects on communicative behavior. With an effect size of 0.35, this meta-analysis shows a small to medium effect size increase in the communicative competence of doctors, which is mostly based on direct pre-post measurements. A small additional effect can be achieved through additional supervision or refresher sessions, which also applies to effects on the participants' attitudes towards death and dying. However, short training programs appear to be less effective.

The following is a brief description of studies that Barth and Lannen (2011) were unable to include in their meta-analysis due to their year of publication.

Niglio de Figueiredo et al. (2015) described that they measured communicative skills at different levels and focused on the transfer of communicative skills to real-life situations.

Goelz et al. (2010) present a concept of CST in relation to the transition from curative to palliative medicine (see also Stubenrauch et al. 2010). In an RCT on their training, they demonstrate moderate to strong effects (Goelz et al. 2011). Bragard et al. (2010) were unable to observe any statistically significant influence of the training programs on burnout. The amount of clinical workload and the overuse of facilitative communication skills (i.e. the effective use of gestures during a conversation to facilitate communication and improve comprehensibility) were associated with oncologist burnout. In addition, side effects of CSTs (Levin et al. 2010), such as non-empathetic feedback and traumatic personal experiences, must also be considered. Trainers must therefore be qualified and undergo further training, e.g. in intervision

groups. In the past, the KoMPASS trainer group benefited from the annual training sessions in Heidelberg with Walter Baile from the MD Anderson Cancer Center in Houston.

Stubenrauch et al. (2012) developed the ComOn checklist, which evaluates the communication skills of an oncologist during a medical consultation (e.g. creating an appropriate opening, exploring the patient's perception during the consultation, using appropriate non-verbal communication, showing empathy). The crucial point here is that it is not the patients but external doctors who carry out the evaluation during communication training. Nevertheless, it is important that the doctor's communication skills are also evaluated by the patients in order to achieve an optimum level of patient satisfaction with the medical consultation and an increase in adherence. To this end, the ComOn checklist has been developed further into the ComOn questionnaire. It is now possible to use a questionnaire as an external assessment tool for medical communication skills in oncology (Wuensch et al. 2022). An example of a ComOn questionnaire item would be: "the doctor starts the conversation appropriately". Another instrument is the Breaking Bad News Rating Scale (AGBS) by Wand et al. (2007). It is used to assess the doctor's communicative competence in a situation in which the doctor communicates a serious diagnosis to the patient. The external assessment is based on 22 items, which are divided into five different categories. An example of an AGBS item would be: "How well did the doctor succeed in creating a suitable environment for the conversation?".

On a content level, different, sometimes very specific aspects of competence can be considered and promoted. Bialer et al. (2011) developed and evaluated a training module for dealing with anger in oncology patients. Before starting the training, the participants received a questionnaire (8 questions, 5-point Likert scale) on how they would assess their current handling of angry patients, as well as a training manual that provided information on the correct handling of patient anger. The training itself consists of a two-hour workshop containing strategies for dealing with patient anger, as well as videos and role plays. Afterwards, the questionnaire was filled-in again and the results were compared with the results before the start of the training. The teaching of prognosis (Step, Ray 2011) is trained and evaluated as part of CST training modules (Brown et al. 2010). Eid et al. (2009) propagate an improvement in communicative skills via the "Breaking Bad News Standardized Patient Intervention" (BBNSPI) developed by them.

Tulsky et al. (2011) investigate the effects of a computer-based training program. First, medical consultations between oncologists and cancer patients were recorded on tape and stored on a CD-ROM. The participants in the control group then received standard training (consisting of a one-hour lecture on communication skills), while the participants in the experimental group received standard training and a training program. The training program includes the aforementioned CD-ROM with audio files that serve as examples of possible communicative behavior. Furthermore, videos were used to demonstrate communicative skills and summarize important teaching points. After the participants in the experimental group had had one month to learn with the CD-ROM, medical consultations with the patients were again recorded on tape. The patients were then asked how much they trusted their oncologist. The results show that the participants in the experimental group used better communication skills after one month and that the patients generally trusted their treating doctor from the experimental group more than doctors from the control group.

Baile (2011) describes methods of small group teaching for a learner-centered approach. Actor patients were used to present a standardized medical history (taking on the role of a cancer patient with a long medical history). This showed that teaching in small groups makes it easier to acquire skills, especially when combined with reflective exercises and role plays (with feedback from the lecturer and other participants). This illustrates how important the learning setting and the qualifications of the teachers are, especially as not all teachers in a medical context are familiar with such methods. Sociodramatic techniques have now been added to the role-playing games (Baile, Blatner 2014). These techniques, such as doubling ("doubling yourself"), contribute significantly to making the role plays more dynamic. In order to raise awareness of the skills acquired in the training sessions, the participants can be asked immediately after each role play in the form of a briefing what they have "taken away" from the role play in order to better anchor what they have achieved with the participants.

Epner and Baile (2011) deal with the "Pyramid of Relational Excellence (PRE)", which is based on "Wooden's pyramid", making it easier to systematize the skills to be taught. The PRE visualizes the most important points within communication training.

Box 43.5 Pyramid of Relational Excellence (PRE)

1. *Preparation.* The lowest level consists of basic individual skills that the trainee should learn, such as showing respect for the patient and creating an appropriate environment in which the conversation can be conducted.
2. *Care.* The second level relates to fundamental communication skills such as showing empathy during a conversation or formulating clear and unambiguous statements.
3. *Help.* The third level refers to advanced communication skills, such as giving the patient a sense of hope and creating an emotional balance within the conversation.
4. *Ultimate Goal.* The top level is the perfection of communication skills that create a healing relationship between the doctor and the patient, which even has a positive influence on the course of the patient's illness.

Epner, Baile 2011

It is also important to examine the Kirkpatrick pyramid with regard to the evaluation of communication training.

Box 43.6 Kirkpatrick pyramid

1. *Reaction.* How did the learner feel about the learning process?
2. *Learning.* What was learned? What new knowledge and skills were acquired?
3. *Behavior.* What has changed in the implementation? Can the newly learned skills be applied?
4. *Results.* What are the results of the learning process in terms of cost reduction, improved quality, increased production, efficiency, etc.?

Kirkpatrick 1994

At the bottom of the list is the evaluation of satisfaction with a training course, followed by self-assessment, followed by external assessment, which leads to the question of how much of it is "received" in clinical practice or by the patient.

Another aspect is the question of which (professional) group is being trained. For example, Langewitz et al. (2010) describe a training course

for oncology nurses. Here too, communication skills are trained using role plays, acting patients and exercise videos. Furthermore, special techniques are taught to train nurses to help patients express their feelings, attitudes and expectations. After one and a half years, an advanced course is held in which the experiences gained since the basic course are discussed and the skills are further deepened. In the advanced course, role-playing with drama patients is carried out again. The role play is then evaluated by the lecturers and the other course participants and compared with the conversations from the basic course in order to recognize progress and identify any weaknesses.

Zill et al. (2014) wrote a comprehensive review in which they identified psychometric test instruments that can be used to evaluate the doctor-patient relationship. A total of eleven measurement instruments were found that contain objective evaluation systems, five that are evaluated from the patient's perspective, two that use both the patient's and the doctor's perspective and one measurement instrument that evaluates the relationship from the doctor's perspective.

In Cologne, the saying goes "jeder Jeck is anders" (everyone is different). This applies not only to the trainers, but also to the participants in communication training. This means that different participants benefit in different ways. Here are just two references: The characteristics of the participants also seem to be important (Libert et al. 2007), such as the participants' defense mechanisms (Bernard et al. 2012).

In their review, Libert et al. (2001) describe that the main problems with CSTs are that the various acquired skills are only questionably maintained in the long term. The sustainability of the effects of communication training is therefore an important area of research. Some of the literature reports a weakening of the effects (Maguire 1996), so that refresher training after 1-2 years is definitely recommended, while in some cases further positive effects can develop in the long-term follow-up after 3-4 years (Gulbrandsen 2013).

Another problem is the successful transfer into clinical practice. In addition, the central challenge in research in this area remains the investigation of the effects of such training on patient-reported outcomes. Evidence of the effects of medical training on patients has yet to be provided (Barth, Lannen 2011, Razavi et al. 2003, Uitterhoeve et al. 2010). This also raises the question of whether and how the skills learned are actually applied in everyday life in terms of performance.

43.4 KoMPASS study

Deutsche Krebshilfe e.V. (German Cancer Aid) funded a multicenter project from 2007 to 2011 with the aim of developing and testing a standardized and effective training program for oncology physicians and scientifically investigating its effectiveness. The information in this section has essentially been taken from the former KoMPASS website which is not existing any longer. The aim was to follow the standards that have already been successfully established in other countries (e.g. England, Switzerland). To this end, the KoMPASS working group was formed from several centers. Care was taken to ensure that the working group consisted primarily of doctors and psychologists with many years of experience in psycho-oncology and experience in further training in medical interviewing and communication.

The KoMPASS training program has now been tested in 41 training workshops. It is geared towards the specific concerns of the participating doctors and enables in-depth learning experiences with effective didactic methods. The practical exercises in small groups are particularly instructive, as training can be based on examples that the doctors experience in their everyday lives. Around 600 oncology doctors have now taken part in one of the KoMPASS training courses. Their feedback unanimously confirms that the KoMPASS training is highly relevant to practice and useful to them in their everyday work. During follow-up courses, participants often report how they were able to apply the teaching methods and practical tips. It is remarkable that the doctors not only report better communication with patients, but are also better able to deal with their own emotions in the respective situation.

To ensure the greatest possible benefit and learning success, KoMPASS training takes place in small groups (maximum 12 participants), with experienced and competent trainers, sufficient time (20 hours in two and a half days plus a refresher session), with specially trained actors who take on the role of patients or relatives, with a high proportion of practical exercises and with video recordings of doctor-patient conversations to work on realistic scenarios, difficult conversation situations and special communication requirements.

43.4.1 Contents of the KoMPASS training course

The content of the training is essentially determined by the matters which are of concern to topics include breaking bad news in all phases of cancer, making a joint treatment decision, dealing with strong emotions in patients and relatives and dealing with existential boundaries, dying and death. The topics are presented in short lectures and discussed together with all participants, as well as supplemented with short exercises appropriate to the topic.

The most important prerequisite for personal learning success is concrete experience. That is why the core of the KoMPASS training is the in-depth examination of the concerns of the participating doctors. In a short case vignette, the participants report on a contact with a patient or family member that remains of concern to them. These case examples are worked on in the small group (4-6 participants) in role plays. During the training, each participant has the opportunity to work on their case with the support of colleagues and trainers.

At the same time, a study was conducted to accompany the KoMPASS training in order to evaluate the training, its benefits and effectiveness. In phase I, a prospective and controlled pre-post design was used to assess the change in communicative competence in the form of a self-assessment of the participating doctors before and 4 months after the KoMPASS training and compared with the assessment of doctors who had not completed the training. Both study-specific (self-efficacy, recorded as perceived difficulty and confidence in dealing with communicative demands) and internationally used questionnaires for recording job-related stress and burnout symptoms (Maslach Burnout Inventory, MBI-D (Büssing, Perrar 1994)) and empathy skills (Jefferson Empathy Scale; Hojat et al., 2002) were used. Complete data sets are available from 262 participating physicians and 181 data sets from non-participants. For all KoMPASS training courses, an evaluation of satisfaction and benefit from the participants' perspective was also carried out for quality assurance purposes (N = 326).

Phase II of the study is conducted prospectively in a one-group pre-post design. The aim is to objectively assess the communicative behavior of the training participants by means of a video evaluation. Video-documented doctor-actor-patient conversations, recorded before and 4 months after training, were evaluated using a standardized rating procedure (modified Roter Interaction Analysis System, RIAS or DCAS) by

trained raters who were blind to whether it was a so-called "pre" or "post" training video. The target sample size of N = 120-160 physicians with video-documented conversations between a physician and an actor-patient on the topic of "breaking bad news" before and 4 months after the training was achieved with 150 complete data sets.

43.4.2 Evaluation of the effectiveness of KoMPASS training

The results on the effectiveness of the KoMPASS training courses relate to the self-assessment of the participating doctors collected by means of questionnaires and to objective changes in the videographies.

With regard to the questionnaire survey, we can already report that 345 KoMPASS participants were compared with a control group. In comparison with a control group, the participants show that doctors feel significantly more confident in dealing with communicative challenges 4 months after the KoMPASS training. Vitinius et al. (2012) report that intensive communication training such as KoMPASS training improves doctors' sense of security in communicatively challenging situations in the medium term and reduces the perceived difficulty of conversations, which indicates improved communicative competence. Gärtner et al. (2012) concluded at PSO Conference in 2012 that, from the doctors' perspective, intensive communication training also improves their empathy skills in comparison with non-participants and increases their professional "personal fulfillment" as a measure of their job satisfaction, which can counteract the development of burnout.

43.4.3 Feedback from KoMPASS participants

The feedback from participants after 4 months indicates an increase in the doctors' self-efficacy and communication skills, personal relief and successful practice transfer. Even experienced clinicians attest to the training's high practical relevance, benefits and personal learning gains. During the refresher session around 4 months after the 2.5-day main training course, the participants reported the following subjective impressions:

- "If I had known that I would be given so many tools here, I would have done the seminar much earlier!"

- "That was the best seminar I've ever done!"
- "I'm more attentive, take more breaks, pay attention to the effect, take my time, pay attention to body language and react to it."
- "The three seconds (pause) stuck in my head..."
- "I deliberately ask more open questions."
- "I'm quicker on the patient in a light way."
- "I no longer feel so shabby when I have to deliver bad news."
- "It has become easier to deal with difficult questions."
- "I find it easier to address feelings and show understanding for feelings..."
- "I'm under less pressure to act, I give the patient more space."
- "I have more opportunities for the conversation to go in a good direction. It's not such a mountain anymore."
- "I pay more attention to my needs and the needs of the patients."

We consider the importance of such feedback to be high, as it directly reflects the (evidence-based) experience of the participants and therefore complements a scientific evaluation using questionnaires and video evaluation. Positive results in the last two areas would not be of any use if there was no positive feedback from participants and acceptance of the training was low.

43.5 KPAP study

The KPAP project (Promotion of the communicative competence and performance of doctors), carried out at the University Hospital of Cologne (applicant: Priv. Doz. Dr. med. Frank Vitinius, Department of Psychosomatics and Psychotherapy, University Hospital Cologne (AöR), Prof. Dr. med. Wolfgang Söllner and Dr. Dipl.-Psych. Barbara Stein, Klinikum Nürnberg, PARACELSUS Medizinische Privatuniversität), investigated whether effects on their communication behavior and psychological parameters can be proven at least three years after the implementation of a training program for doctors working in oncology at the University Hospital Cologne.

The communication training program "Communicative Competence" was based on the KoMPASS training program and is open to physicians of all specialties. As part of the KPAP study, the communicative competence and performance of doctors caring for oncology patients was ex-

amined. Participants were trained in a group setting over two and a half days using an interactive training approach (knowledge transfer, pair and group exercises and role-playing with an acting patient). It was recommended that six units of refresher training be carried out at the earliest three months after participation in the basic training (see handbook chapter 16).

The research situation on the long-term effects of communication training is inadequate and inconsistent. In order to contribute to this question, the oncology physicians participating in the KPAP project completed questionnaires at the time of the basic training, the refresher training and three years after the basic training. The evaluation included all instruments from the KoMPASS study as well as an instrument for self-assessment of communication skills (Parle et al. 1997). Further evaluation instruments were used for the evaluation of the video recordings by expert and patient raters: ComOn questionnaire (Wuensch et al. 2022), the AGBS scale (Aufklärungsgesprächsbewertungsskala; Wand et al. 2007) and CARE questionnaire (*Consultation and Relational Empathy*; Neumann et al. 2008).

43.6 Further information

Organizations that deal with the topic of communication in general and communication in oncology:

- Working Group for Psychooncology in the German Cancer Society (PSO):
- Deutsches College for Psychosomatic Medicine (DKPM):
- European Association of Psychosomatic Medicine (EAPM):
- International Association for Communication in Healthcare (EACH):

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

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