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Development of an Online Communication Skills Training Program for Oncologists Working with Adolescents and Young Adults

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There are two purposes to this study. The first purpose was to develop a communication skills training (CST) program for oncologists working with adolescents and young adults (AYA-CST). The second purpose was to evaluate the program's feasibility. The online AYA-CST program was a half-day workshop including a didactic lecture, role-playing with simulated patients and discussions in a small group. All six oncologists who participated in the program satisfactorily completed it. Our AYA-CST program seems feasible and will be tested further in a randomized control study.

Keywords: adolescent and young adult, communication skills training, oncologist, online program

Introduction

ADOLESCENTS AND YOUNG adults (AYAs, age 15–39 years) with cancer face many issues, such as schooling, employment, and fertility. Previous studies showed that they had unmet information and supportive care needs.^{1–3} It is important for medical providers to understand their various needs and provide appropriate care that is different from those of other generations. However, communication with AYAs can be difficult because most medical providers are not ready for conversations with them, and do not have time to respond to discussions or patient reactions.^{4,5}

Communication skills training (CST) is a way for medical professionals to learn to communicate with patients.⁶ Essig et al. reported that they developed a 2-day CST program focused on adolescent oncology, which was based on findings from focus groups with adolescent patients, their parents, and health professionals in Switzerland, Germany, and Austria, and the global curriculum of the American and European

Societies of Clinical/Medical Oncology.^{7–9} Their program was unique in that it focused on the learners' needs. Confidence of the participants who were physicians and nurses working with adolescents with cancer regularly in Switzerland and Germany, improved in exchanging information, responding to emotions, managing uncertainty, and making decisions.

Because cultural factors affect (1) patients' perceptions of disease, disability, and suffering, (2) their degrees and expressions of concern about them, and (3) their responses to treatments and relationships to individual physicians,^{10–12} it is difficult to apply a Western program to Japan without modification. Although individual autonomy is respected in the West,¹⁰ families are involved in the process of giving information to cancer patients in Asian cultures.^{13,14} We had developed a program, which is called SHARE-CST, that takes into consideration the communication preferences of Japanese adult cancer patients regarding the disclosure of bad news.^{12,15,16} The SHARE-CST program encourages

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long time, for opinions on the program and incorporated her opinions into the program. Although AYAs have a wide range of ages and challenges, based on discussions between committee members and an AYA cancer survivor, the program was designed to learn communication with AYAs, not just adolescents. The aims, topics, and contents in the AYA-CST program are given in Table 1.

Online CST workshop setting

The AYA-CST program was developed as an online workshop because it can be held during the COVID-19 pandemic, and it is easier for oncologists to participate from all over the country. We used the Zoom® platform for the online CST workshop. One group consisted of three participants and four facilitators: two main-sub facilitators, a technical facilitator, and a back-up facilitator. The main facilitator mainly facilitates group discussions. The sub facilitator dictates role-plays and facilitates group discussions. The technical facilitator is responsible for operating the course, such as turning the camera on/off for participants and receiving feedback from standardized patients (SPs). A back-up facilitator takes the place of the other facilitators when they have technical problems. Everyone turns on the camera for discussions and group work. During role-playing, a participant who plays the role of a doctor puts on a white coat, and only the doctor and SP turn on their cameras. As a result, only the doctor and an SP are projected on the screen, and their facial expressions can be clearly seen.

Feasibility evaluation of the AYA-CST program

Participants and procedures. The criteria for eligibility were oncologists who had previously learned SHARE-CST and were not involved in AYA-CST development. We recruited participants by using the JPOS mailing list for certified facilitators of CST. An electronic survey was sent to participants pre- and postworkshop. The preworkshop survey contained the participants' demographics and confidence in communication. The postworkshop survey contained confidence, usefulness of the program, and satisfaction with the program. Finally, participants were asked to give their opinions and impressions of the program in a free-form description. The purpose of the survey was indicated at the beginning of the survey. It was explained to the participants that they could withdraw at any time if they wished to. Responses were considered consent to participate. Responses to the questionnaire were voluntary, and confidentiality was maintained throughout all investigations and analyses. This study was approved by the Institutional Review Board and Ethics Committee of National Cancer Center (2021-473) and was conducted in accordance with the principles laid down in the Declaration of Helsinki.

Measurements

Confidence in communication with AYAs with cancer. Confidence was assessed with a questionnaire consisting of 19 items by Essig et al.⁷ (Table 3). We translated them into Japanese and changed "adolescent" in the original to "AYA" (items 1–17). Responses are rated on a 5-point Likert scale ranging from "not at all confident" to "very confident."

Usefulness of the program. Ten items of the workshop were evaluated: dyadic lecture, AYA-SHARE protocol, giving feedback to others, getting feedback from others, role-playing, the facilitators' general approach, the facilitators' suggestions, the simulated patients' approach, scenarios, and relevance to clinical situations.²⁰ Each item was measured on a 10-point Likert scale from 1 to 10, ranging from "not at all useful" to "very useful."

Satisfaction with the program. Satisfaction was measured with almost the same four items used by Essig et al.⁷: (1) the training was effective. (2) The training provided me with useful skills, (3) the training has helped me in discussions with AYAs. (4) I would recommend this training to my colleagues. These items could be answered with "disagree" or "agree." Satisfaction of the entire workshop was measured by one item with the 10-point Likert scale from 1 to 10, ranging from "not at all satisfied" to "very satisfied."

Demographics. The preworkshop survey included age, sex, specialty, clinical experience, clinical experience in oncology, the number of AYAs with cancer treated annually and difficult communication situations with AYAs with cancer.

Analysis

Participants' responses were analyzed descriptively using median, mean, standard deviations, and range. The scale on confidence was divided into three groups: not confident (1, 2), midpoint (3), and confident (4, 5). Responses to the two open-ended questions were analyzed using the content analysis approach²⁶ by two investigators (M.F., M.O.). They first read all the comments independently and divided them into semantic units that included words and sentences. Semantic units were coded; the codes were compared with each other and classified into categories according to their resemblances. If there was a difference in coding decisions, we discussed it until a consensus was reached.

TABLE 2. CHARACTERISTICS OF PARTICIPANTS

	n=6
Age, years	
Median	52
Range	46–55
Gender	
Female	2
Male	4
Specialty	
Hematology	2
Obstetrics and gynecology	2
Palliative care	2
Years of clinical experience	
Mean (SD)	24.2 (5.3)
Range	17–30
Years in cancer care	
Mean (SD)	22.8 (5.7)
Range	15–30
Number of AYAs with cancer seen yearly	
5–10	3
>11	3

SD, standard deviation.

TABLE 3. SELF-ASSESSED CONFIDENCE BEFORE AND IMMEDIATELY AFTER THE ADOLESCENT AND YOUNG ADULT-COMMUNICATION SKILLS TRAINING WORKSHOP

Variable	Before the workshop	Immediately after the workshop
	n	n
I feel ... when I have to tell an AYA patient ...		
1. that he/she has cancer—when prognosis good.		
Not confident (1, 2)	1	0
Midpoint (3)	0	0
Confident (4, 5)	5	6
2. that he/she has cancer—when prognosis is bad		
Not confident (1, 2)	1	0
Midpoint (3)	3	1
Confident (4, 5)	2	5
3. when he/she has a relapse		
Not confident (1, 2)	1	0
Midpoint (3)	3	1
Confident (4, 5)	2	5
4. when curative therapy is replaced with palliative therapy.		
Not confident (1, 2)	1	0
Midpoint (3)	4	2
Confident (4, 5)	1	4
5. I am ... when I have to deal with psychological problem of an AYA patient.		
Not confident (1, 2)	1	0
Midpoint (3)	3	2
Confident (4, 5)	2	4
I am ... when I have to talk to an AYA patient about ...		
6. about sexuality.		
Not confident (1, 2)	1	0
Midpoint (3)	2	3
Confident (4, 5)	3	3
7. about participating in a clinical trial.		
Not confident (1, 2)	1	0
Midpoint (3)	3	2
Confident (4, 5)	2	4
8. informed consent before beginning a therapy		
Not confident (1, 2)	1	0
Midpoint (3)	2	1
Confident (4, 5)	3	5
9. possible side effects from treatment		
Not confident (1, 2)	0	0
Midpoint (3)	2	0
Confident (4, 5)	4	6
Particular clinical situations		
10. The AYA patient and the parents see the need for a therapy differently.		
When mediating between patient and parents, I feel ...		
Not confident (1, 2)	1	0
Midpoint (3)	3	4
Confident (4, 5)	2	2
11. The AYA patient wants to be solely responsible for a therapy decision		
I am ... that I can adequately take his/her attitude into account in the decision process.		
Not confident (1, 2)	2	0
Midpoint (3)	3	4
Confident (4, 5)	1	2
12. The AYA patient doesn't want the parents to be informed about the results of an examination		
Not confident (1, 2)	2	0
Midpoint (3)	4	4
Confident (4, 5)	0	2
13. An AYA patient withdraws more and more. I feel ... getting back into a conversation with him/her		
Not confident (1, 2)	3	0
Midpoint (3)	2	3
Confident (4, 5)	1	3

(continued)

TABLE 3. (CONTINUED)

Variable	Before the workshop	Immediately after the workshop
	n	n
14. Because of hair loss and massive changes to the skin, an AYA patient is sad and angry		
Not confident (1, 2)	1	0
Midpoint (3)	4	3
Confident (4, 5)	1	3
15. The AYA patient needs a therapy, which will compromise fertility permanently. I feel ... addressing fertility preservation with a male patient.		
Not confident (1, 2)	1	0
Midpoint (3)	4	2
Confident (4, 5)	1	4
16. The AYA patient needs a therapy, which will compromise fertility permanently. I feel ... addressing fertility preservation with a female patient.		
Not confident (1, 2)	0	0
Midpoint (3)	4	1
Confident (4, 5)	2	5
17. The AYA patient is not taking important medication. I feel ... addressing noncompliance		
Not confident (1, 2)	1	0
Midpoint (3)	2	2
Confident (4, 5)	3	4
18. A decision concerning therapy needs to be taken. I feel ... judging the extent the adolescent would like to be involved in decision-making		
Not confident (1, 2)	1	0
Midpoint (3)	4	3
Confident (4, 5)	1	3
19. The adolescent has to be informed about a complex intervention. I feel ... explaining the intervention in developmentally appropriate terms.		
Not confident (1, 2)	1	0
Midpoint (3)	4	3
Confident (4, 5)	1	3

The scenes and themes addressed in this workshop are given in bold.

Results

Participant characteristics

Six oncologists participated in the workshop and completed it. Their characteristics are given in Table 2. All participants answered in the preworkshop that they faced difficult communication situations with AYAs with cancer. We classified them into four categories such as “breaking bad news” ($n=3$), “patients with unique characteristics” ($n=2$), “dealing with emotions” ($n=1$), and “response to family members” ($n=4$). The “breaking bad news” category included recurrence, anticancer treatment cessation, prognosis, and the inability to preserve fertility. Each participant selected a scenario according to their specialty and a scene setting as follows: diagnosis of acute myeloid leukemia, recurrence of acute myeloid leukemia, diagnosis of advanced stomach cancer, diagnosis of uterine cancer, and diagnosis of advanced ovary cancer.

Confidence for communicating with AYAs with cancer

The scenes and themes featured in this workshop (item nos. 2, 3, 4, 8, 9, 15, 16) are given in bold in Table 3. In the preworkshop, the only items that four to five of the six participants indicated that they were confident about disclosing the diagnosis when prognosis is good (item no. 1) and talking about possible side effects from treatment (item no. 9). The proportion of participants who felt confident increased in 17

items at the postworkshop (Table 3). The items that did not change in number were the participants who answered that they were confident about discussing sexuality (item no. 6) and mediating between an AYA with cancer and parents (item no. 10).

Usefulness and satisfaction

The median scores (range) of usefulness as follows: dyadic lecture, AYA-SHARE protocol and giving feedback to others were 8.5 (8–10); getting feedback from others, the facilitators’ general approach, the facilitators’ suggestions, and relevance to clinical situations were 9 (8–10); the simulated patients’ approach, and scenarios were 9 (9–10); role-playing was 10 (8–10). All participants agreed that the training was effective and helpful, that it provided them with useful skills and they would recommend it to their colleagues. The median score (range) of satisfaction with the training program was 10 (8–10). All of them provided feedback on the program.

Participants’ opinions and impressions of the program

The free opinions and impressions of the program were classified into six categories: “proposed program structure” ($n=6$), “meaningful learning from discussions” ($n=2$), “program eligibility” ($n=1$), “usefulness of the program” ($n=4$), “proper facilitation” ($n=2$), and “skilled standardized patients” ($n=1$). The “proposed program structure”

category included comments that it is extended to 2 days or 10 hours, and to include multiple role-plays in the program.

Discussion

To our knowledge, this is the first report about developing a CST program for oncologists working with AYAs with cancer. Our program seemed feasible, because all participants were able to complete the program and were very satisfied with it. The AYA-CST program can be applied to Japanese physicians who experience difficult communication situations with AYAs, such as “breaking bad news,” “patients with unique characteristics,” and “dealing with emotions.”

The major difference from the CST program developed by Essig et al. is that our program focused on training for oncologists. When Japanese oncologists see AYAs with cancer, especially those who usually treat elderly patients, they might not know how to deal with AYAs and talk mainly to their families. Therefore, the program was developed to learn basic communication skills based on SHARE through role playing, and it emphasized the importance of facing each AYA patient first, not the family. We expect that the experience of role-playing and discussions gave them confidence in communication with AYAs and motivated them to try the skills they got at the workshop in clinical practice.

The results of the oncologists’ confidence after the workshop showed that they felt confident about communicating with AYAs in a variety of settings, including diagnosis of advanced cancer, recurrence, and discussing about fertility. Their communication confidence regarding discussions about sexuality (item no. 6) and mediating between an AYA with cancer and their parents (item no. 10) did not change. Reasons for this might be time constraints, participant-led role-plays, and scenes and themes not covered in this program. Because two thirds of oncologists cited “response to family members” as a difficult communication situation, and because family involvement can bring many challenges to health professionals,²⁷ it may be necessary to consider adding SPs who play family members.

Telemedicine, videoconferences, and online seminars have become widespread owing to the COVID-19 pandemic.^{28,29} An online workshop is convenient, can reduce travel time and costs, and can be held in a pandemic. However, our online program requires twice as many facilitators as a face-to-face program. If we can reduce costs even more, the online program will be a breakthrough in the effort to spread CST methodology. Considering the rarity of AYA cancers and the convenience of online training, we believe that an online AYA-CST program should be continued even after the pandemic is over.

This preliminary study had several limitations. First, because the sample size of this study was so small and it did not set up a control group, we could not discuss about the efficacy. Second, the scale used in Essig et al.’s study was translated into Japanese and used to evaluate the participants’ confidence, but it included issues that were not addressed in our program, so the evaluation scale might not be appropriate. Confidence assessments may need to be adapted to the Japanese program. Third, while we were developing the program, the committee asked an AYA cancer survivor, who has supported many AYAs with cancer for a long time, for opinions on the program.

In the future, the program would become better by incorporating the opinions of more survivors and their families. Finally, because it was developed as an advanced course position of the SHARE-CST program, the AYA-CST program is for oncologists who have previously learned the SHARE-CST program, not all oncologists who practice with AYAs.

Although the online AYA-CST program seemed feasible, it still needs to be modified to make it a better program considering the opinions of more AYAs with cancer, their families, study participants, and developmental committee members. Our next step is to modify the program for all oncologists practicing with AYAs and test it further in a randomized control study.

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Authors’ Contributions

All authors are members of the AYA-CST development committee. The study assessments were developed by M.O. and M.F. M.O. and M.F. analyzed the participants’ data. M.O. wrote an outline of the article, which was carefully revised, edited, and discussed with M.F. and Y.U. All authors have read and approved the final version of the article.

Author Disclosure Statement

No competing financial interests exist.

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