

Improve the counselling skills of doctors and nurses in cancer care

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The diagnosis and treatment of cancer cause considerable psychological distress and morbidity.¹ But this is resolved in only a minority of patients because those concerned in their care tend to avoid the emotional aspects.² They distance themselves for two main reasons. They lack the skills to handle the difficult problems and strong emotions that may emerge if they talk with patients and relatives in any depth. Also, they fear that probing into how a person is adjusting psychologically will do more harm than good.

Fortunately, many doctors and nurses who care for cancer patients realise that their difficulties in communicating with patients and their relatives stem from insufficient training and are eager to remedy this. We describe how to run short intensive workshops to help doctors and nurses improve their skills in interviewing, assessment, and counselling.

Structure

Participants—Nurses often complain that they cannot talk openly with cancer patients because doctors will not let them do so and that doctors ignore important feedback about patients. Doctors usually counter these complaints by stating that nurses are too eager to “pass the buck” to them and do not understand how difficult it is to break bad news and initiate unpleasant treatments. We therefore include both doctors and nurses in the workshops so that these opposing views can be aired, discussed, and resolved. We try to ensure equal representation of hospital and community staff, for the latter tend to excuse their reluctance to talk with cancer patients on the basis that they have still to hear formally from the hospital what patients have been told about their illness and prognosis.

Size—We limit our workshops to 20 people. This ensures that participants are involved fully and have at least one opportunity to practise their skills and be given feedback.

Setting—While workshops can be held in the workplace, it is difficult for participants to avoid being contacted to deal with clinical problems. Nor is there much opportunity for informal sharing of concerns at the end of each day. Consequently, our workshops are residential. We use a centre that has comfortable rooms suitable for both large and small group work and also provides good food and accommodation. This allows participants to devote their attention to the workshops instead of complaints about the setting.

Duration—Three to four days are needed to cover the main agenda and permit discussion about how to apply newly acquired skills while ensuring personal survival.

Teaching

TUTORS

The workshops require experienced doctors and nurses to acknowledge that they find certain counselling situations hard to cope with because they lack the relevant skills. They also have to watch demonstration videotapes that show patients and relatives in predicaments. So, strong feelings may be aroused and

powerful memories triggered. This requires two experienced tutors (preferably a doctor and a nurse) to monitor reactions and intervene publicly or privately when necessary, which minimises the risk that participants will be harmed and allows potentially damaging situations to be used constructively as in the following example.

While an experienced nurse watched a videotape of an interview between a tutor (PM) and a patient with cancer she became very angry. Her anger seemed out of all proportion, and so the second tutor (AF) asked her if she would explain her reaction. She disclosed that her mother was dying of cancer and suffering terrible pain. She believed her mother was being neglected by the medical staff but felt she could not complain because they were her colleagues. In describing this both she and other participants realised that she was blaming the tutor for other doctors' apparent shortcomings.

METHODS

It is crucial that teaching methods are congruent with the models of interviewing, assessment, and counselling being taught. So, the beginning of a workshop mirrors the initial phase of an assessment interview with a patient who has requested help. (Key techniques are in parentheses).

BEGINNING

We introduce ourselves (self introduction), give the aims of the workshop and the methods we will use (orientation), and check if these are acceptable (negotiation). We add that we are willing to adapt our methods to meet participants' needs (sensitivity to need). Participants are then asked to explain who they are, why they have come, and what they are hoping for (establishing expectations).

They are next asked to think of and disclose problems they have experienced in recent weeks when talking with cancer patients, relatives, and colleagues which they would like to have handled better. They are split into two small groups to do this. Each group appoints a leader who ensures that each participant contributes at least one problem (promoting honest disclosure of key problems). Another member keeps a record of the problems (recording key problems). It is explained that the success of the workshop depends, like counselling, on the level of disclosure. If important problems remain hidden they cannot be discussed and resolved.

When the group reforms a rapporteur from each group describes the problems that have been disclosed. We clarify the nature and extent of each problem by inviting the participants who volunteered the problems to give more detail (clarification, precision). As each problem is clarified it is listed on a flipchart (compiling a problem list). Once all the problems have been mentioned the participants are asked if there are any other problems they would like help with (screening for any other problems).

AGREEING THE GOALS

As in counselling there may be too many problems to cover in the time available. Priorities have to be

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decided and realistic goals set. Participants are asked in turn to rate how essential it is for them to cover each listed problem on a scale from 0 or no relevance to 10 or most essential. We advise them to think only of their own needs and work situation when giving a rating verbally (disclosing real *v* expected needs). Group scores are calculated for each problem (range 0-200). Problems are then relisted on a flipchart in rank order from the most to least essential.

The agenda of the workshop is decided on the basis of the top eight problems (table I). A problem which

TABLE I—*Problem list*

	Score (maximum=200)	% Of maximum
Breaking bad news	180	90
Patient who has been lied to	178	89
Basic interviewing/assessment	177	88.5
Handling difficult questions	175	87.5
Dealing with the angry patient	171	85.5
Challenging denial	168	84
Sudden, unexpected death	163	81.5
Bereaved relatives	158	79
Breaking collusion	153	76.5
Handling the withdrawn patient	149	74.5

produced both very high and very low scores is also included to check the accuracy of participants' self awareness. The problems to be covered are summarised by a tutor and the group asked if this agenda is acceptable (summarise goals, check acceptability). We then explain that the other problems listed will be dealt with briefly in a later session (reviewing unfinished business).

BASIC INTERVIEWING AND ASSESSMENT

We suggest that participants tackle the least difficult problem first to generate confidence, which is invariably how quickly to establish an empathic relationship with a patient and identify key problems. A videotape showing a tutor conducting an assessment is used to show the aspects to be covered and skills to be used. We expose ourselves to scrutiny to emphasise that we are not perfect interviewers or counsellors and can tolerate constructive feedback.

The aspects covered are history of the patient's illness and treatment to date; patient's perceptions, psychological reactions, and view of the future; and the impact of illness and treatment on the patient's daily life, mood, and key relationships. The following techniques are demonstrated: acknowledging, organising, clarifying, and exploring key verbal and non-verbal cues; how to keep patients to the point and use time optimally but avoid alienation; encouraging precise accounts so that patients make the effort to remember and describe experiences and feelings fully and accurately; and encouraging the expression of feelings.

Key strategies shown are dealing with patients' concerns before professional concerns—like a review of physical systems; ensuring full coverage of one topic before moving to another—for example, the nature and extent of a body image problem before talking about the partner's responses; and obtaining a list of all key problems before giving advice or attempting any resolution. The tapes are stopped at key points and participants invited to suggest which aspects are being covered and why and which techniques and strategies are being used. The interviewing and assessment model is thus made explicit. Once participants have assimilated the model they are split into two groups, each with a tutor, to practise basic interviewing and assessment skills by role play.

USE OF ROLE PLAY

Role play allows participants to practise under controlled conditions, and audiotape recording permits

playback and discussion. Otherwise much time can be lost in debating whether or not certain skills were used. Most participants are wary of role play because of adverse experiences. We explain, therefore, that we will make it as safe but realistic as possible by observing the following rules: (a) Every participant will do a role play. (b) The patient, relative, or colleague presenting the problem will be played by the person who volunteered it as a difficult problem in the initial small group discussions. (c) A participant should not play a particular role—for example, a bereaved relative—if it is too close to an adverse personal experience (bereavement). (d) The role player will not make the problem more difficult than it was in real life. (e) The doctor or nurse tackling the problem will be given an explicit, simple but realistic brief. (f) Each role player will stay within the brief given. (g) If a participant feels stuck in the role play he or she must call time out, otherwise the tutor will do so to avoid embarrassment and humiliation. (h) When a role play is stopped the doctor or nurse and the person playing a patient, relative, or colleague will first be asked to comment on how he or she thinks the interaction is going. (i) Other members of the group will then be asked to identify strengths in the doctor or nurse's performance. (j) Only when they have exhausted all strengths will they be allowed by the tutor to suggest why the doctor or nurse got stuck. (k) The group (not the doctor or nurse) will be asked to offer other strategies. (l) The doctor or nurse will then be invited to test out these strategies in role play until the problem is resolved.

BRIEFING

The participant playing the patient, relative, or colleague is taken out of the room and briefed by a tutor who uses the participant's real life experience of the problem to develop the brief. The role player then returns to the room to sit down and "get into role" while the tutor briefs the doctor or nurse. For example: Sheila is a 32 year old housewife who was told two years ago that her breast cancer had been cured by surgery and radiotherapy. She has now developed a recurrence on her scar line and has widespread bony metastases. She has been referred to you as the medical oncologist for advice about further treatment. Your task is to assess her and determine her current problems and whether they are physical, social, or psychological. Remember to signal time out if you feel stuck and I will then ask the group to suggest alternative strategies.

FEEDBACK

The doctor then joins the "patient" and is asked to begin the role play by asking an open question—for example, what problems have brought you here today? The tutor starts the audiotape recording and the role play continues until time out is signalled by the doctor or tutor, usually some three to four minutes later. Each participant in the role play is asked to comment on how it is going, emphasising good points first. The group is then requested to highlight what they liked. Only when no more strengths are forthcoming are constructive criticisms invited by the tutor who asks: Why did the doctor get stuck? The tutor then asks the group to suggest what other strategies might be tried (emphasising a shared approach to problem solving). These strategies are then discussed and tested out in further role play (testing out strategies). The tutor resists offering a solution unless the group fail to resolve the problem (encouraging participants to generate their own solutions). These exercises in role play concerning basic interviewing and assessment are carried out in a 90 minute session (table II).

PROBLEMS IN COUNSELLING

Role play is also used to help participants to learn how to resolve other problems on the main agenda,

such as "how to break bad news" and "relate to an angry patient." Explicit briefs are given based on real life situations disclosed by the participants.

For example, John had a lymphoma diagnosed two years ago and was treated with chemotherapy and radiotherapy. He experienced severe adverse effects, particularly conditioned vomiting. He nearly opted out but was persuaded to continue by the argument that he had a 95% chance of a complete cure. His lymphoma has returned and further chemotherapy has been suggested. He feels very angry and is refusing treatment.

John is then played by the doctor who encountered this predicament. This gives the doctor valuable insight into what it might have been like to be on the receiving end of care.

These problems are covered in subsequent sessions (table II), and these sessions, like counselling, can be intense and emotionally draining but enriching. They

TABLE II—*Timetable and agenda for workshop*

Day 1:	
3 30 pm	Tea
4 00 pm	Self introduction and orientation
4 30 pm	Identification of problems (small groups)
5 30 pm	Reporting back and negotiating agenda
6 45 pm	Dinner
8 00 pm	Basic interviewing and assessment I
9 00 pm	Close
Day 2:	
9 15 am	Basic interviewing and assessment II (videotape demonstration and discussion)
10 45 am	Coffee
11 15 am	Basic interviewing and assessment (role play)
12 45 pm	Lunch
2 00 pm	Breaking bad news (role play)
3 45 pm	Tea
4 15 pm	Patient advocacy (video)
5 15 pm	Close
Day 3:	
9 15 am	Dealing with anger (role play)
10 15 am	The withdrawn patient (role play)
11 15 am	Dealing with a misinformed patient (role play)
12 45 pm	Lunch
2 15 pm	Sudden unexpected death (role play)
	Challenging denial (role play)
3 45 pm	Tea
4 15 pm	Breaking collusion (video)
5 15 pm	Close
Day 4:	
9 15 am	Breaking collusion (video) continued
10 00 am	Unfinished business (discussion)
10 45 am	Coffee
11 15 am	Survival (discussion)
12 45 pm	Lunch
1 45 pm	Evaluation
3 00 pm	Close

are separated by long coffee and lunch breaks (need for time out) and further videotape demonstrations which are both serious and humorous (need for light relief). The role playing is distributed equitably within each group so that no one takes an undue burden (sharing the load).

Ending

Unfinished business—After completion of the agreed goals unfinished business is reviewed.

Survival—Participants are invited to discuss the methods they use to ensure that they cope when confronted by the emotional demands of caring for cancer patients. They also consider how they might cope if they relinquish their distancing tactics and apply their new skills when they return to their place of work. The importance of sharing concerns promptly with colleagues, whether formally in support groups or informally, is emphasised.

Review—Participants are asked to say what they found most and least helpful in the workshop (asking for feedback) and to suggest improvements (demonstrate willingness to learn).

Follow up—A one and a half day workshop is held

six months later to discuss how far participants have been able to apply what they learnt and obtain adequate support. It also allows them to discuss if their new skills were effective (validation) and to practise more difficult counselling tasks.

Discussion

We are attempting to meet an important need for training in counselling skills. An analysis of audiotapes of the role playing in the initial workshops has confirmed that this need is real and substantial. But we continue to be impressed by the willingness of experienced doctors and nurses to subject themselves to such close scrutiny. For it is hard for experienced doctors and nurses to admit to being inadequate. Fortunately, the feedback from participants has been consistently positive with most participants claiming that they have improved their skills and become more confident about assessing and counselling cancer patients.

The follow up workshops also suggest that these improvements are maintained, but we have started on an objective study to determine if these claims of short and longer term improvement are confirmed by independent assessment.

We are grateful to the Cancer Research Campaign and Help the Hospices for supporting the development and evaluation of these workshops.

- 1 Greer S. Cancer: psychiatric aspects. In: Granville-Grossman K, ed. *Recent advances in clinical psychiatry*. London: Churchill Livingstone, 1985:87-103.
- 2 Maguire P. Barriers to psychological care of the dying. *Br Med J* 1985;291:1711-3.

(Accepted 6 June 1988)

Update box for *Oxford Handbook of Clinical Specialties*, p 209

Towards eliminating measles, mumps, and rubella

From today the long awaited live vaccine against measles, mumps, and rubella (MMR vaccine) is available in the United Kingdom. Offer this combined vaccine to boys and girls aged 12-18 months. Give a single deep subcutaneous or intramuscular dose of 0.5 ml into the upper arm or anterolateral thigh. Children between 18 months and 5 years old who have not had the vaccine (even if they have had single measles vaccine) may be given it with the preschool booster of diphtheria, tetanus, and polio—but use a different site. There is no upper age limit to this immunisation.

Side effects: A rash and fever from days 5-10 for about two days (so offer advice on how to control temperature); occasional non-infectious parotid swelling (from week 3).

Contraindications: Fever; pregnancy (advise against becoming pregnant for at least one month); a previous live vaccine within three weeks or an injection of immunoglobulin within three months; primary immunodeficiency syndromes (not including infection with the human immunodeficiency virus (HIV) or AIDS); steroid treatment (equivalent to ≥ 2 mg/kg/day for more than a week in the previous three months); leukaemia; lymphoma; recent radiotherapy; anaphylaxis induced by egg, neomycin, or kanamycin (these two antibiotics are vaccine preservatives). Non-anaphylactoid allergies are not contraindications and neither is a history of seizures or febrile convulsions. — J M LONGMORE

Principal source

Joint Committee on Vaccination and Immunisation. *Immunisation against infectious disease*. London: Department of Health, 1988:59-64.