

Development and preliminary evaluation of communication skills training program for oncologists based on patient preferences for communicating bad news

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ABSTRACT

Objective: The purposes of this study were to develop a communication skills training (CST) workshop program based on patient preferences, and to evaluate preliminary feasibility of the CST program on the objective performances of physicians and the subjective ratings of their confidence about the communication with patients at the pre- and post-CST.

Methods: The CST program was developed, based on the previous surveys on patient preferences (setting up the supporting environment of the interview, making consideration for how to deliver bad news, discussing about additional information, and provision of reassurance and emotional support) and addressing the patient's emotion with empathic responses, and stressing the oncologists' emotional support. The program was participants' centered approach, consisted a didactic lecture, role plays with simulated patients, discussions and an ice-breaking; a total of 2-days. To evaluate feasibility of the newly developed CST program, oncologists who participated it were assessed their communication performances (behaviors and utterances) during simulated consultation at the pre- and post-CST. Participants also rated their confidence communicating with patients at the pre-, post-, and 3-months after CST, burnout at pre and 3 months after CST, and the helpfulness of the program at post-CST.

Results: Sixteen oncologists attended a newly developed CST. A comparison of pre-post measures showed improvement of oncologists' communication performances, especially skills of emotional support and consideration for how to deliver information. Their confidence in communicating bad news was rated higher score at post-CST than at pre-CST and was persisted at 3-months after the CST. Emotional exhaustion scores decreased at 3-months after CST. In addition, oncologists rated high satisfaction with all components of the program.

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Significance of results: This pilot study suggests that the newly developed CST program based on patient preferences seemed feasible and potentially effective on improving oncologists' communication behaviors what patients prefer and confidence in communicating with patients.

KEYWORDS: Communication skills training, Patients' preference, Bad news, Patient-physician relationship

INTRODUCTION

The communication skills of physicians delivering bad news about cancer, such as an advanced cancer diagnosis, can affect the degree of a patient's distress (Uchitomi et al., 2001; Schofield et al., 2003; Morita et al., 2004). However, many physicians do not have a standard strategy for delivering bad news to patients (Baile et al., 2000) and find it difficult to communicate bad news with cancer patients and their relatives (Fujimori et al., 2003).

Therefore, communication skills training (CST) has been designed to enhance physicians' communication skills when delivering bad news and has been shown to improve both the objective performance of physician and subjective ratings of their confidence about communicating with patients (Baile et al., 1999; Fallowfield et al., 2002; Jenkins & Fallowfield, 2002; Back et al., 2007; Lenzi et al., 2010). However these CST programs do not necessarily have a strong theoretical basis (Girgis et al., 1999; Cegala & Lenzmeier, 2002) and reflect patient preferences (Butow et al., 1996; Parker et al., 2001). Consequently, the provision of CST cannot always improve patients' distress and satisfaction with care (Shilling et al., 2003; Fellows et al., 2004). Meanwhile, patient preferred communication features have been linked with lower psychological distress and higher satisfaction levels (Schofield et al., 2003). Therefore, interventions in enhancing physicians' communication skills that are based on the patients' preferences are needed (Cegala et al., 2002; Schofield et al., 2003).

According to our previous reports about patient preferences for physicians' styles of communicating bad news, cancer patients have preferred that physicians communicate bad news while taking into account setting up the supportive environment of the interview, giving consideration on how to communicate the bad news, providing various information which patients would like to know, and providing reassurance and emotional support to patients and their relatives (Fujimori et al., 2005; 2007; 2009). We also suggested the most difficult communication issues for physicians in clinical oncology were breaking bad news (for example, a diagnosis of advanced cancer, recurrence, and stopping anti-cancer treatment), providing emotional support, and dealing with patients' emotional responses (Fujimori et al., 2003).

The purposes of this study were to develop a CST workshop program for oncologists to improve patient preferred communication skills when breaking bad news based on the previous studies and to evaluate preliminary feasibility the CST program on the objective performances of physicians and the subjective ratings of their confidence about the communication with patients at the pre- and post- CST.

METHODS

CST Program Development

The CST program was designed to aim that oncologists learn to patients' perceive preferences and needs for communication of each patient, based on our previous surveys on the preferences of Japanese cancer patients regarding the disclosure of bad news (Fujimori et al., 2005; 2007; 2009). The conceptual communication skills model was consisted of four dimensions, referred to as SHARE: S, setting up the supporting environment of the interview; H, make consideration for how to deliver the bad news; A, discuss about various additional information which patients would like to know; and RE, provision reassurance and addressing the patient's emotion with empathic responses. Especially, the program stressed RE, because it is the most important patient preference (Fujimori et al., 2007; Fujimori & Uchitomi, 2009) and also one of the most difficult communication skills for physicians (Fujimori et al., 2003). The conceptual model had been confirmed content validity by two psychiatrists, a psychologist and two oncologists who were experienced attending staff in clinical oncology with knowledge about communication between patients and oncologists.

The program is participants' centered approach and consisted of a 1-hour computer-aided didactic lecture with text and video, 8-hours role plays with simulated patients, discussions and an ice-breaking; a total of 2-days, based on previous studies (Fujimori et al., 2003; Fellows et al., 2004) and discussion about feasibility by two psychiatrists and a psychologist who were experienced attending staff in clinical oncology with knowledge about communication between patients and oncologists. The program provides the suitable communication in the three situations of breaking bad news to patients: diagnosis

of advanced cancer, recurrence, and stopping an anti-cancer treatment. These situations were found difficult to deal with in practice by physicians (Fujimori et al., 2003). To role-play, many scenarios were drawn up tailored to each participants' specialties. The participants were divided into groups of four each with two facilitators.

The facilitators were psychiatrists, psychologists, and oncologists, all of whom had had clinical experience in oncology for 3 or more years and had participated in specialized 30-hours training workshops on facilitating workshops on communication skills in oncology. The simulated patients, who had had experience in medical school for 3 or more years, were also participated 30-hours training workshops. To strengthen in improving physicians' empathic responses, facilitators lead a discussion and role plays on the potential needs and emotion of the patient and communication which patients prefer physicians' empathic responses during a lecture and discuss the SPs express during role plays.

Evaluation of the CST Program

Participants

Oncologists in Japan attended the CST program at National Cancer Center Hospital East. All participants were expected by their hospital directors and local district medical directors to promote palliative care in their hospitals and surrounding area. After giving written informed consent, the oncologists participated in the study.

Measurement

The Objective Performance of Communication Skills. Before and after participating in the workshop, oncologists' performances, such as behaviors and utterances, were recorded using a video-camera during a consultation with simulated patients, while they were asked to tell a patient an inoperable advanced cancer. Their consultation video files were assessed in random order by two blind-raters independently, who trained more than 60-hours in order to standardize the interpretation and application of the assessment based on the manuals, using two assessment tools. First, we prepared the 32 items for the impressions of participants' performances during simulated consultation, which were based on the patient preferences: setting up the supporting environment of the interview, consideration for how to deliver the bad news, discussing additional information, and providing reassurance and addressing the patient's emotion with empathic responses (Fujimori et al., 2007). The average Spearman correlation coefficients of each intra-coder were 0.79 and 0.76.

The average Spearman correlation coefficient of inter-coder was 0.78, except for five items which showed the correlation coefficients were less than 0. Thus, we only evaluated 27 items.

The Roter interaction analysis system (RIAS) (Roter et al., 1995) was also used for analyzing the objective utterances of communication skills. The RIAS has 42 mutually exclusive items for physicians and patients' utterances. In the RIAS, the unit of analysis is the "utterance," defined as the smallest discriminable speech segment. Every utterance is assigned to one of the mutually exclusive items that were aligned with our training, and then researchers condense them into fewer theoretically meaningful clusters depending on the purpose of their studies. The Japanese version of RIAS was used to evaluation of consultations in Japanese oncology setting by Ishikawa et al. (2002). In this study, we focused on the 23 items and added three items; silence, warning sign, and ask for perception about bad news, of the following behaviors for physicians; setting up the interview, medical and the other information given, active listening, and reassurance and empathic responses. The average Spearman correlation coefficients of each intra-coder were 0.86 and 0.82. The average Spearman correlation coefficient of inter-coder was 0.83, except for one item which showed the correlation coefficients were less than 0. Thus, we only analyzed 25 items.

Confidence in Communication with Patients.

Confidence in communication with patients was assessed with a questionnaire consisting of 21 items by Baile et al. (1997). It measures the self-efficacy of communication skills in breaking bad news. All items were rated on a 10-point Likert scale from 1 to 10, ranging from "not at all" to "extremely." The previous studies had adopted this questionnaire to evaluate CST programs (Fujimori et al., 2003; Baile et al., 1997).

Burnout. The Maslach Burnout Inventory (MBI) is a well validated, self-administered, and a standardized instrument for evaluating burnout (Maslach & Jackson, 1986). The Japanese version of MBI was validated by Higashiguti et al. (1998). It consists of 22 items and three subscales: depersonalization (five items), personal accomplishment (eight items), and emotional-exhaustion (nine items). Each item was measured on a seven-point Likert scale ranging from 0 to 6 according to frequency with which feeling/attitudes are experienced.

Evaluation of the Workshop. Nine components of the workshop (lecture on communication skills, giving feedback to others, getting feedback from others, using role play, facilitators' general approach,

facilitators' suggestion, simulated patients, scenarios, and relevance of the workshop to their own clinical practice) were evaluated. Each item was measured on a 11-point Likert scale from 0 to 10, ranging from "not at all" to "usefulness" (Fujimori et al., 2003).

Procedure

Before the workshop, participants were informed about this study and gave consent in writing for participant of this study. After that, they were required to participate in a simulated consultation in which they were asked to give the diagnosis of inoperable advanced cancer to a simulated-patient and to complete a pre-training survey regarding demographic characteristics, confidence in communication with patients, and MBI. Demographic characteristics included age, sex, marital status, specialty, clinical experience, and clinical experience in oncology. After workshop, participants were required to participate in a simulated consultation similar to the first, fill in the questionnaires consisted of confidence in communication, and evaluate the workshop. Three-months after the workshop, all participants were asked to answer a set of questionnaires that consisted of confidence and MBI.

Analysis

The scores of participants' possessed skill at pre-CST were compared using paired *t*-test with the scores at post-CST. We also estimated the confidence of participants and compared the rating score at pre-CST with post-CST and 3-months after CST using repeated measures analysis of variances (ANOVAs). When ANOVAs showed a significant difference, post hoc tests were performed. Each factor score of MBI was compared at pre-CST with 3-months after CST using *t*-test. The statistical analysis was used the SPSS 19.0 software.

RESULTS

Participant Characteristics

Sixteen oncologists participated in the workshop. Their characteristics were shown in Table 1.

Performance of Communicating Bad News

In each pair of bad news consultations, the score of 13 out of 27 categories of SHARE significantly increased, related to mainly "make consideration for how to deliver the bad news" and "provision reassurance and addressing the patients' emotion with empathic responses" (Table 2). In each participant, the mean of 9.7 skills were had higher score at the post-CST. In RIAS, the utterances assigned 11 of 25 categories significantly increased, related to "setting up interview," "reassurance and empathic responses," "medical and the other information giving," "reassurance and empathic responses," and "how to deliver the bad news" (Table 2). The utterances of each participant increased in the mean of 10.5 skills at post-CST.

Confidence for Communicating Bad News

All items of the confidence related to communication with patient of participants were significantly higher scores at post-CST than at pre-CST and maintained at the high level in 3-months after CST (Table 3).

Burnout

Compared with pre-CST, the mean score of all subscales at 3-months after CST decreased (emotional exhaustion: 11.64 ± 3.77 and 10.29 ± 3.75 , respectively; $p = 0.04$, depersonalization: 18.60 ± 9.41 and 14.47 ± 9.48 , respectively; $p = 0.08$, personal accomplishment: 33.13 ± 9.65 and 28.80 ± 12.66 , respectively; $p = 0.01$).

Table 1. Participant characteristics ($N = 16$)

	Median (range), years	N	%
Age	36 (29–55)		
Clinical experience	10 (3.8–25.0)		
Clinical experience in oncology	8 (2.3–25.0)		
Sex			
Male		11	68.8
Female		5	31.3
Specialty			
Digestive		7	43.8
Thoracic		4	25.0
Head & Neck		2	12.5
Urology		1	6.3
Gynecology		1	6.3
Medical oncology		1	6.3

Table 2. Mean Score of Total Performances for Physicians During Consultations by Assessing SHARE and RIAS Categories

	Pre-CST		Post-CST		t	p	% of physicians who improve the skill
	Mean	S.D.	Mean	S.D.			
SHARE categories							
Setting up the supporting environment of the interview	9.14	2.35	10.64	1.50	1.66	n.s. ^a	42.9
Greeting a patient cordially	2.79	1.84	3.71	1.07	2.06	* ^b	28.6
Looking at patient's eyes and face	3.50	0.94	3.86	0.53	1.16	n.s.	28.6
Taking sufficient time	2.85	1.35	3.07	1.21	0.42	n.s.	28.6
Make consideration for how to deliver the bad news	13.94	8.03	22.13	6.44	3.45	** ^c	85.7
Encouraging a patient to ask questions	2.43	1.74	2.43	1.60	0.00	n.s.	21.4
Not beginning bad news without preamble	1.50	1.55	4.00	0.00	6.01	**	85.7
Asking how much you know about patient's illness before breaking bad news	1.79	1.93	2.93	1.63	2.00	*	35.7
Not using technical words	2.64	1.44	3.21	0.97	1.85	*	42.9
Using actual images and test data	1.29	1.86	2.50	1.95	2.58	*	35.7
Writing on paper to explain	1.36	1.91	0.57	1.45	-1.32	n.s.	7.1
Checking to see that patients understand	1.43	1.55	2.64	1.82	2.46	*	64.3
Checking to see whether talk is fast-paced	0.57	1.45	1.78	1.71	2.08	*	50.0
Communicating clearly the main points of bad news	0.93	1.33	2.07	1.27	3.08	**	50.0
Discuss about additional information	14.64	3.71	16.21	2.83	1.13	n.s.	42.9
Answering patient's fully	3.50	1.16	3.71	0.83	0.59	n.s.	14.3
Explaining the status of patient's illness	2.93	1.38	3.29	0.99	0.92	n.s.	42.9
Telling the prospects of cancer cure	3.86	0.36	3.07	1.54	-1.76	† ^d	14.3
Providing information on support services	0.00	0.00	0.14	0.53	1.00	n.s.	7.1
Discussing patient's daily activities and work in the future	1.29	1.33	1.29	1.64	0.00	n.s.	35.7
Explaining a second opinion	0.00	0.00	1.14	1.88	2.28	*	28.6
Checking questions	3.07	1.44	3.57	0.76	1.07	n.s.	35.7
Provision reassurance and addressing the patient's emotion with empathic responses	18.50	7.30	24.64	3.59	3.56	**	85.7
Asking about patient's worry and concern	0.86	1.46	2.07	1.69	2.19	*	64.3
Saying words to prepare mentally	1.57	1.91	3.29	1.14	3.12	**	57.1
Remaining silent for concern for patient feelings	1.36	1.82	2.29	1.49	1.87	*	57.1
Accepting patient's expressing emotions	2.43	1.45	3.50	0.76	2.90	**	71.4
Saying words that soothe patient feelings	2.79	1.42	3.21	1.25	1.31	n.s.	35.7
Telling in a way with hope	3.43	1.45	3.71	0.61	0.72	n.s.	14.3
Telling what patient can hope for	3.50	1.16	3.79	0.58	0.84	n.s.	21.4
Assuming responsibility for patient's care until the end	2.57	1.45	2.79	1.37	0.56	n.s.	35.7
RIAS categories							
Setting up the interview	1.93	0.92	2.71	1.44	1.92	*	42.9
Greeting/social conversation	1.93	0.92	2.71	1.44	1.92	*	42.9
Reassurance and empathic responses	14.90	8.97	22.93	9.21	2.64	*	71.4
Empathy	0.50	0.65	1.00	1.24	1.71	†	42.9
Show compassion for worry and concern	0.21	0.43	0.71	0.73	2.19	*	42.9
Reassurance	3.29	1.98	3.50	1.99	0.43	n.s.	35.7
Tell partnership	1.00	0.00	0.71	0.73	-0.84	n.s.	21.4
Show understanding	4.79	3.83	8.21	4.98	2.28	*	71.4
Show supportive response	2.00	3.21	4.93	7.12	1.89	*	42.9
Show concern for patient	0.71	0.99	1.50	1.88	1.71	†	35.7
Show respect/gratitude	0.14	0.53	0.00	0.00	-1.00	n.s.	0
Validation	1.07	1.07	1.21	1.19	0.38	n.s.	35.7
Silence	1.14	2.25	0.71	0.99	0.81	n.s.	21.4
Open-ended question about psychosocial feelings	0.14	0.53	0.43	0.65	1.17	n.s.	35.7
Medical and the other information giving	10.43	2.38	9.22	3.66	1.43	n.s.	28.6
Information giving about medical condition	3.93	1.28	5.00	2.63	1.41	†	71.4
Information giving about therapeutic regimen	5.43	1.99	3.07	1.38	-3.49	**	7.1
Information giving about psychosocial feelings	0.29	0.47	0.79	0.70	1.99	†	7.1

Continued

Table 2. Continued

	Pre-CST		Post-CST		t	p	% of physicians who improve the skill
	Mean	S.D.	Mean	S.D.			
Counseling and direction about medical condition/therapeutic regimen	0.79	1.05	0.36	0.50	-1.47	†	14.3
How to deliver the bad news	9.50	4.54	16.79	5.42	3.90	**	92.9
Open-ended question about medical condition	0.50	0.94	1.64	0.93	5.55	**	78.6
Open-ended question about lifestyle	0.00	0.00	0.29	0.47	2.28	*	28.6
Counseling and direction	3.86	1.56	5.00	1.88	1.63	†	57.1
Ask for opinion	0.14	0.36	0.57	0.85	1.71	†	28.6
Ask for permission	0.71	1.14	0.86	1.03	0.38	n.s.	42.9
Ask for understanding	0.14	0.36	1.07	1.33	2.51	**	100
Ask for perception about bad news	0.43	0.51	1.00	0.78	2.83	**	100
Warning	0.43	0.65	1.21	0.80	3.29	**	100
Comfirm comprehension/inform exactly/rephrase	3.29	2.05	5.14	2.32	2.68	**	50.0

a: n.s.= not significant

b: *p < .05

c: **p < .01

d: †p < .10

Evaluation of the Workshop

Participants reported to form a high estimate (mean scores; 7.88–9.13) of all CST components (Table 4).

DISCUSSION

This study developed CST program based on patient preferences and the newly developed CST program seemed feasible and potentially effective and might be applied to medical education for physicians, especially in Japanese culture which are characterized by a family-centered communication style, an emotionally demanding patient preference and a little more 'paternalistic' physician-patient relationship (Fujimori et al., 2005; 2007; 2009).

Two assessment tools for performances, which are the SHARE as an assessment of impressions of participants' performances and the RIAS as an assessment of participants' utterances, showed the similar results. As we intended, our developed CST program might be strengthened in improving physicians' empathic responses and active listening skills. Especially, more than 70% of participants have improved performances of "not beginning bad news without preamble" and "accepting patient's expressing emotions" categories of SHARE, and "show understanding," "open-ended question about medical condition," "ask for understanding," "ask for perception about bad news," and "warning" categories of RIAS. Taken together with these results, the newly developed CST program might be expected for physicians to be able to provide an emotional support for

patients, resulting in their reduce distress such as depression and anxiety.

In contrast, physicians' behaviors and utterances related to most categories of "discussing about additional information" of SHARE did not change between pre- and post-CST. One possible reason might be that participants of this study might have already had these communication skills, because the scores of "telling the prospects of cancer care" category of SHARE had been already rated high scores at pre-CST. Another possible reason might be that this program does not have insufficient effect on "providing information of support services" of SHARE. Most participants might not have enough knowledge about the psychosocial support services and daily activities. If so, it might be effective to add in the CST program a lecture of information which most patients had not possess.

All subjective confidence ratings about communication increased significantly after CST and maintained 3-months after it. This result showed that this CST program allowed participants to work on these areas in a manner that was inspiring confidence, and had an either equaling or surpassing efficacy on participants' confidence compared to our previous program which showed 18 of 21 items had improved after CST and maintained 3-months after CST (Fujimori et al., 2003).

As the results of participants' burnout, the emotional-exhaustion and depersonalization showed positive changes 3-months after CST, however the personal accomplishment also decreased significantly. This result did not replicate the result of our

Table 3. Scores of the Participants' Self-Rating Confidence Scale for Communication with Patient

	Pre-CST		Post-CST		3-months after CST		F	p	Multiple comparison
	Mean	S.D.	Mean	S.D.	Mean	S.D.			
Creating comfortable setting	4.13	2.07	7.20	1.47	7.20	1.97	15.59	** a	t1 ^b < t2 ^c , t3 ^d
Assessing patient's ability to discuss bad news	4.93	2.02	7.07	1.39	7.27	1.28	17.94	**	t1 < t2, t3
Detecting verbal cues	5.13	1.77	7.20	1.32	7.73	1.28	21.95	**	t1 < t2, t3
Encouraging family presence	6.40	1.59	8.07	1.58	8.27	1.16	11.46	**	t1 < t2, t3
Assessing current knowledge	5.73	1.58	7.40	1.24	7.93	1.33	16.04	**	t1 < t2, t3
Detecting patient's anger	5.40	1.96	6.73	1.53	7.27	1.49	7.83	**	t1 < t2, t3
Including family in discussion	6.53	1.36	7.87	1.88	8.40	1.18	12.29	**	t1 < t2, t3
Detecting nonverbal cues	4.53	1.85	6.80	1.57	7.20	1.74	17.87	**	t1 < t2, t3
Assessing how much the patient wants to know	4.33	1.95	6.73	1.44	7.00	1.81	23.87	**	t1 < t2, t3
Detecting anxiety	4.40	1.55	6.73	1.49	7.13	1.51	28.06	**	t1 < t2, t3
Planning discussion in advance	5.73	1.58	7.73	1.94	8.07	1.71	17.50	**	t1 < t2, t3
Detecting patient's sadness	4.80	1.52	6.67	1.59	7.20	1.52	21.50	**	t1 < t2, t3
Confirming patient's understanding of cancer	5.00	1.65	7.13	1.46	7.67	1.45	20.43	**	t1 < t2, t3
Checking to see that information was received accurately by patient	4.73	1.62	6.87	1.55	7.53	1.46	26.05	**	t1 < t2 < t3
Providing information in small increments	4.87	1.85	6.47	1.73	7.53	1.36	18.33	**	t1 < t2 < t3
Avoiding medical jargon	5.80	1.66	7.33	1.88	8.07	1.33	13.00	**	t1 < t2 < t3
Reinforcing and clarifying information	5.80	1.37	7.40	1.64	8.13	1.19	15.48	**	t1 < t2 < t3
Responding empathetically to patient's feelings	5.27	1.67	7.47	1.46	8.27	1.10	27.95	**	t1 < t2 < t3
Planning a strategy for disclosing information	5.33	1.84	7.53	2.01	8.13	1.46	18.71	**	t1 < t2, t3
Handling patient's emotional reactions	4.33	1.72	7.13	1.55	7.40	1.30	28.80	**	t1 < t2, t3
Managing your own response to patient distress	4.50	1.83	7.07	1.44	7.21	1.37	30.33	**	t1 < t2, t3

a: **p < .01

b: t1 = Pre-CST

c: t2 = Post-CST

d: t3 = 3 months after CST

previous study which showed participants' emotional-exhaustion worsened 3-months after CST (Jenkins & Fallowfield, 2002) and this CST program was suggested improving the physicians' emotional-exhaustion and depersonalization, like the speculations in previous studies that physicians' burnout had decreased after CST (Baile et al., 1997; Ramirez et al., 1995). Although this study also cannot explain the reason why the participants' personal accom-

plishment for their job decreased 3-months after CST, it is possible that participants have intensified their attempts to be empathic with patients and realized that the consultations were more challenging. It might have to be assessed at longer follow-up to provide a more satisfactory explanation of the phenomenon.

The participants evaluated the CST program fully positively on all components, suggesting that they were generally satisfied with the content, methodology, and facilitators of the workshop: a learner-centered model as well or better as our previous study (Fujimori et al., 2003). These results of this study showed the CST program suggested to useful to physicians.

Two limitations of this study should be noted. First, this preliminary study did not set up the control group and the participants are small because the aims of this study were development and feasibility evaluation of CST program based on patient preferences. Our next step study will perform randomized control trial, as the results of this study suggested a newly developed CST program was the feasible and potentially effective. Second, this study did not evaluate the impact of this CST program on

Table 4. Usefulness of the CST Program

	Mean	S.D.	range
Diadic lecture on communication skills	7.88	1.67	5–10
Giving feedback to others	8.38	1.26	7–10
Getting feedback from others	8.94	1.12	7–10
Using role play	9.00	1.15	7–10
The facilitators' general approach	9.13	1.09	7–10
The facilitators' suggestion	9.13	1.09	7–10
Simulated patient Scenarios	9.00	1.10	7–10
Relevance of the workshop to their own clinical practice	8.25	1.34	6–10

patients' outcomes such as patients' distress and satisfaction. Future research efforts should be evaluated the patients' outcomes.

In conclusion, a newly developed CST program based on patient preferences is suggested being feasible and potentially effective on communication behaviors of oncologists, confidence in communicating with patients, and emotional exhaustion. A randomized control study to conclude the developed CST program is effective was needed further.

REFERENCES

- Back, A.L., Arnold, R.M., Baile, W.F., et al. (2007). Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. *Archives of Internal Medicine*, *167*, 453–460.
- Baile, F.W., Lenzi, R., Kudelka, A.P., et al. (1997). Improving physician-patient communication in cancer care: outcome of a workshop for oncologists. *Journal of Cancer Education*, *12*, 166–173.
- Baile, W.F., Kudelka, A.P., Beale, E.A., et al. (1999). Communication skills training in oncology. Description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness. *Cancer*, *86*, 887–897.
- Baile, W.F., Buckman, R., Lenzi, R., et al. (2000). SPIKES-A six-step protocol for delivering bad news: Application to the patient with cancer. *Oncologist*, *5*, 302–311.
- Butow, P.N., Kazemi, J.N., Beeney, L.J., et al. (1996). When the diagnosis is cancer: patient communication experiences and preferences. *Cancer*, *77*, 2630–2637.
- Cegala, D.J. & Lenzmeier Broz, S. (2002). Physician communication skills training: A review of theoretical backgrounds, objectives and skills. *Medical Education*, *36*, 1004–1016.
- Fallowfield, L., Jenkins, V., Farewell, V., et al. (2002). Efficacy of a cancer research UK communication skills training model for oncologists: A randomised controlled trial. *Lancet*, *359*, 650–656.
- Fellowes, D., Wilkinson, S. & Moore, P. (2004). Communication skills training for health care professionals working with cancer patients, their families and/or carers. *Cochrane Database System Review*, *2*, CD003751.
- Fujimori, M., Oba, A., Koike, M., et al. (2003). Communication skills training for Japanese oncologists on how to break bad news. *Journal of Cancer Education*, *18*, 194–201.
- Fujimori, M., Akechi, T., Akizuki, N., et al. (2005). Good communication with patients receiving bad news about cancer in Japan. *Psychooncology*, *14*, 1043–1051.
- Fujimori, M., Akechi, T., Morita, T., et al. (2007). Preferences of cancer patients regarding the disclosure of bad news. *Psychooncology*, *16*, 573–581.
- Fujimori, M. & Uchitomi, Y. (2009). Preferences of cancer patients regarding communication of bad news: A systematic literature review. *Japanese Journal of Clinical Oncology*, *39*, 201–216.
- Girgis, A., Sanson-Fisher, R. & Schofield, M.J. (1999). Is there consensus between breast cancer patients and providers on guidelines for breaking bad news? *Journal of Behavioral Medicine*, *25*, 69–77.
- Higashiguchi, K., Morikawa, Y., Miura, K., et al. (1998). The development of the Japanese version of the Maslach burn-out inventory and the examination of the factor structure. *Nippon Eiseigaku Zasshi*, *53*, 447–555 (in Japanese).
- Ishikawa, H., Takayama, T., Yamazaki, Y., et al. (2002). The interaction between physician and patient communication behaviors in Japanese cancer consultations and the influence of personal and consultation characteristics. *Patient Education and Counseling*, *46*, 277–285.
- Jenkins, V. & Fallowfield, L. (2002). Can communication skills training alter physicians' beliefs and behavior in clinics? *Journal of Clinical Oncology*, *20*, 765–769.
- Lenzi, R., Baile, W.F., Costantini, A., et al. (2010). Communication training in oncology: Results of intensive communication workshops for Italian oncologists. *European Journal of Cancer Care*, *20*, 196–203.
- Maslach, C. & Jackson, S. (1986). *Maslach Burnout Inventory*. Palo Alto: Consulting Psychologist's Press.
- Morita, T., Akechi, T., Ikenaga, M., et al. (2004). Communication about the ending of anticancer treatment and transition to palliative care. *Annals of Oncology*, *15*, 1551–1557.
- Parker, P.A., Baile, W.F., de Moor, C., et al. (2001). Breaking bad news about cancer: patients' preferences for communication. *Journal of Clinical Oncology*, *19*, 2049–2056.
- Ramirez, A.J., Graham, J., Richards, M.A., et al. (1995). Burnout and psychiatric disorder among cancer clinicians. *British Journal of Cancer*, *71*, 1263–1269.
- Roter, D.L., Hall, J.A., Kern, D.E., et al. (1995). Improving physicians' interviewing skills and reducing patients' emotional distress. Randomized clinical trial. *Achieve of Intern Medicine*, *155*, 1877–1884.
- Schofield, P.E., Butow, P.N., Thompson, J.F., et al. (2003). Psychological responses of patients receiving a diagnosis of cancer. *Annual of Oncology*, *14*, 48–56.
- Shilling, V., Jenkins, V. & Fallowfield, L. (2003). Factors affecting patient and clinician satisfaction with the clinical consultation: Can communication skills training for clinicians improve satisfaction? *Psychooncology*, *12*, 599–611.
- Uchitomi, Y., Mikami, I., Kugaya, A., et al. (2001). Physician support and patient psychologic responses after surgery for nonsmall cell lung carcinoma: A prospective observational study. *Cancer*, *92*, 1926–1935.