



Difficult medical encounters in oncology: What physicians need. An exploratory study

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ABSTRACT

Objective: The objective of this study was to assess how often medical oncology professionals encounter difficult consultations and if they desire support in the form of training.

Methods: In February 2022, a survey on difficult medical encounters in oncology, training and demographics was set up. The survey was sent to 390 medical oncology professionals part of the OncoZON network of the Southeast region of the Netherlands.

Results: Medical oncology professionals perceive a medical encounter as difficult when there is a dominant family member ($n = 27$), insufficient time ($n = 24$), or no agreement between medical professional and patient ($n = 22$). Patients involved in these encounters are most often characterized with low health literacy ($n = 12$) or aggressive behavior ($n = 10$). The inability to comprehend difficult medical information or perceived difficult behavior complicates encounters. Of the medical oncology professionals, 27–44% preferred a training as a physical group meeting (24%) or an individual virtual meeting (19%).

Conclusion: Medical oncology professionals consider dominant or aggressive behavior and the inability to comprehend medical information by patients during consultations as difficult encounters for which they would appreciate support.

Innovation: Our results highlight concrete medical encounters in need of specific education programs within daily oncology practice.

1. Introduction

Communication in oncology is challenging. Clinicians must bring devastating news and patients may respond to this with fear, grief, denial, or anger. These strong emotions may make clinicians uncomfortable. Within the time constraints of clinical practice and scant training to prepare, clinicians are faced with the challenge to help patients cope [1], but also bring across complex medical information and reach a treatment decision, preferably via shared decision-making (SDM). Therefore, one of the strong recommendations of the consensus guideline of the American Society for Clinical Oncology is to develop clinician training on communication that includes empathy skills, self-awareness with enough repetition to foster a learning curve [2].

Fortunately, communication skills training for clinicians has shown

to improve patient satisfaction [3] and leads to higher self-efficacy in managing health, greater involvement in cognitive reappraisal, and decreased emotional distress among cancer survivors [4]. Also, deliberate practice training and simulated difficult patient encounters are effective in improving resident's skills to deal with difficult encounters [5,6] as well as improved radiation oncology trainee's confidence and knowledge [7]. Despite these promising results, after resident training, clinicians obtain limited support to manage difficult encounters in their complex consultations in their sparse time available.

While 16%–30% of the consultations in general are considered difficult [8–10], in oncology, evidence is scarce with only one study showing 25% of the cancer encounters coded as 'demanding' [11]. Since oncology consultations are further complicated by substantial physical and psychological distress among cancer patients [12] and psychological factors seem to play a prominent role in physicians' satisfaction [13],

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it can be expected that the percentage of difficult consultations within oncology are well in line with previous studies, or may even be on the top of the range. Approximately one-third of cancer patients will develop a mood or anxiety disorder [14]. Factors related to patients' psychological status are especially related to the five domains of patient vulnerability being frequent healthcare users; psychological comorbidity; health comorbidity; risky behaviors and a precarious social situation [10]. The communication in the consultation room may in addition be compromised by patient's relatives, who are perceived, in some cases, as being even more "difficult" than the patients themselves [15].

In addition, the clinician's skills influence the perceived consultation as more or less difficult. Especially, physicians with poorer psychosocial attitudes, as reflected by higher scores on the Physician's Belief Scale, experience encounters as difficult [16]. Factors negatively influencing communication include among others clinician's communication skills and stress management [17] as well as specific decisional conflict interfering with the ability of a clinician to address treatment outcomes in a decision-making encounter [18]. Situational factors of influence include time pressure, conflicts [17,19,20] or the delivery of bad news [21].

For physicians to become engaged and proactive in tackling difficult encounters it is imperative that their intrinsic motivation is presently based on the psychological needs of autonomy, awareness of competence, and sense of relatedness [22]. Therefore, to support medical oncology professionals in dealing with difficult encounters it is imperative to know which encounters are considered difficult by medical oncology professionals and what kind of training they would prefer to diminish its effect in current daily practice. Therefore, the aim of this study was to assess for which difficult consultations medical oncology professionals desire support in the form of training and what kind of training they would appreciate most.

2. Materials and methods

2.1. Design

In February 2022, we conducted a quantitative survey among oncology professionals in the OncoZON network of the Southeast region of the Netherlands, consisting of nine hospitals and one radiation oncology institute [23]. The digital survey was developed by a researcher in oncology and reviewed by an oncology nurse and an oncology physician. The survey consisted of ten multiple choice questions related to difficult medical encounters, professional positions and work experience. The option to include free text was given as well. Given the sensitive topic and the high work pressure among these professionals during COVID-19 times and the pilot methodology, the survey was kept completely anonymous and limited demographic variables were asked (see appendix 1).

2.2. Participants

This survey was sent to the 390 participating medical oncology professionals. Participant characteristics and preferences were described using the number of patients and percentages.

2.3. Survey

In the survey, a non-exhaustive list of training options were given. The training options, including a short description can be found in Table 1.

2.4. Statistical analysis

Descriptive statistics were performed using IBM SPSS Statistics for Windows (version 27; Armonk, NY, USA, IBM Corp.).

Table 1

Training options, and a short description thereof provided to the participants of the survey.

Training options	Description
Physical group	Face to face group session
Individual	
virtual	An online training sessions which can be done individually
Online platform	A platform in which the training can be requested but where also support can be given or additional information
Virtual group	An online group training
Bootcamp	Short term, intense training sessions designed to prepare for the practical reality of the consultation
Physical in room	An observer who would be in the consultation room to observe (difficult) encounters and give feedback later on
Virtual in room	A camera will record (difficult) encounters which can be studied
None	No training needed
Other	Defined by the participant

3. Results

3.1. Participants' characteristics

In total, 45 (12%) oncology professionals, consisting of 37 oncology physicians, 1 resident, 1 physician assistant and 6 oncology nurses filled in the survey of which 66% encountered difficult consultations regularly or very often (Fig. 1). The majority of respondents had >10 years of experience in the oncology field ($n = 35$). Seven respondents had 6–10 years of experience and three respondents had 0–5 years of experience (Table 2). The years of experience did not significantly affect how professionals perceived the consultations ($P = 0.17$), although only the professionals with >10 year's experience indicated that difficult conversations occurred very often ($n = 8$).

3.2. The nature of difficult encounters

We asked the oncology professionals when they observed a consultation as difficult (Fig. 2A). The most mentioned answers included a dominant family member ($n = 27$), insufficient time ($n = 24$), no agreement between medical professional and patient ($n = 22$) and the situation when explanations are not understood by the patient ($n = 18$). Bad news was mentioned by 16 of the respondents. Besides describing the difficult oncology consultation, we also asked the oncology professionals which patients were most often involved in difficult

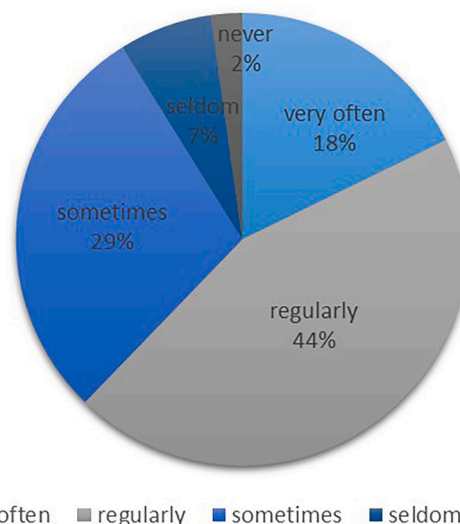


Fig. 1. Frequency in likert scale categories how often oncology professionals encounter difficult conversations ($n = 45$).

Table 2

Participants' characteristics of medical oncology professionals participating in the survey ($n = 45$).

Professional position	Years of experience	Difficult encounters
Physician ($n = 37$) Resident ($n = 1$) Physician Assistant ($n = 1$)	>10 y ($n = 31$)	very often ($n = 7$) regularly ($n = 13$) sometimes ($n = 7$) seldom ($n = 3$) never ($n = 1$)
		regularly ($n = 1$) sometimes ($n = 4$)
		regularly ($n = 1$)
	6–10 y ($n = 5$)	regularly ($n = 1$) regularly ($n = 1$) regularly ($n = 1$)
		regularly ($n = 1$)
		very often ($n = 1$) regularly ($n = 2$) sometimes ($n = 1$) regularly ($n = 1$)
Oncology nurse ($n = 6$)	>10 y ($n = 4$)	regularly ($n = 1$) sometimes ($n = 1$)
	6–10 y ($n = 2$)	regularly ($n = 1$) sometimes ($n = 1$)

consultations (Fig. 2B). According to oncology professionals, patients involved in these encounters are perceived as having low health literacy ($n = 12$) and aggressive behavior ($n = 10$). In the category 'other', respondents described patients inability to comprehend difficult medical information ($n = 6$), patients expressing difficult behavior simultaneously (e.g. a verbose and aggressive patient) ($n = 2$), a highly educated patient ($n = 1$) and not defined ($n = 3$). In the category 'inability to comprehend difficult medical information', participants elaborated that these patients included "frail elderly sometimes demented patients with family", "patients who search a lot but then do not understand the data and do not want to accept it" or "patients with cognitive limitations or psychiatric problems".

3.3. Support to handle difficult encounters

Oncology professionals were asked for which consultations they would like to receive support in the form of training. The options suggested were based on scientific literature and personal communication with care professionals. Most desirable support included a training to deal with a dominant third person (44% answered yes or very much), an aggressive patient (44% answered yes or very much) and the situation when explanations are not understood (27% answered yes or very much) (Fig. 3). In the open text suggestions, most heard suggestions included training for patients with a different cultural background or demanding, dissatisfied patients.

The majority of the oncology professionals prefers a physical and classical approach ($n = 17$, 24%). In decreasing preference this is followed by individual virtual training ($n = 13$, 19%), an online platform ($n = 11$, 16%) and virtual group training ($n = 9$, 13%). The respondents, who chose the option "other", included suggestions for feedback and simulation (Fig. 4).

4. Discussion and conclusion

4.1. Discussion

Our results indicate that difficult medical encounters occur regularly in everyday clinical practice and are in need of more support. This need is especially pressing for encounters in which a dominant third person is present during the consultation or when patients express aggressive behavior or have the inability to comprehend medical information. Below we discuss these encounters more specifically.

While the three-talk model for SDM [24] provides support for the multistage consultation process, it only considers two persons in the conversation as indicated in the SHARE approach [25]. Since, patients are often accompanied by a caregiver in the consultation, the companion

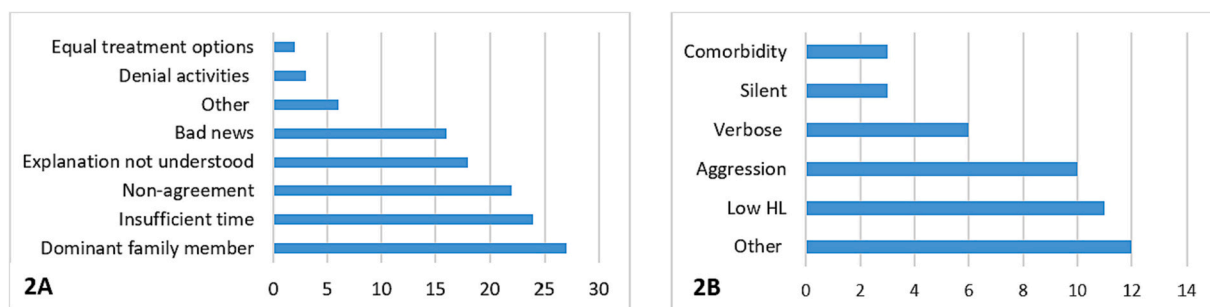


Fig. 2. A. Respondents indicated when they observe a consultation as difficult and 2B. which patients are involved in difficult consultations (in absolute numbers; $n = 45$).

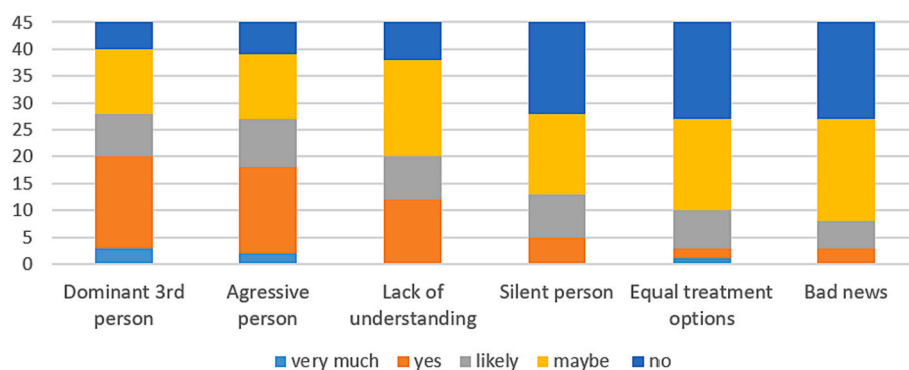


Fig. 3. The desirability of a training for difficult situations according to the situation and a likert scale, showing that there is especially demand for training when in the case of a dominant third person, an aggressive person or a patient who is unable to understand the medical information ($n = 45$).

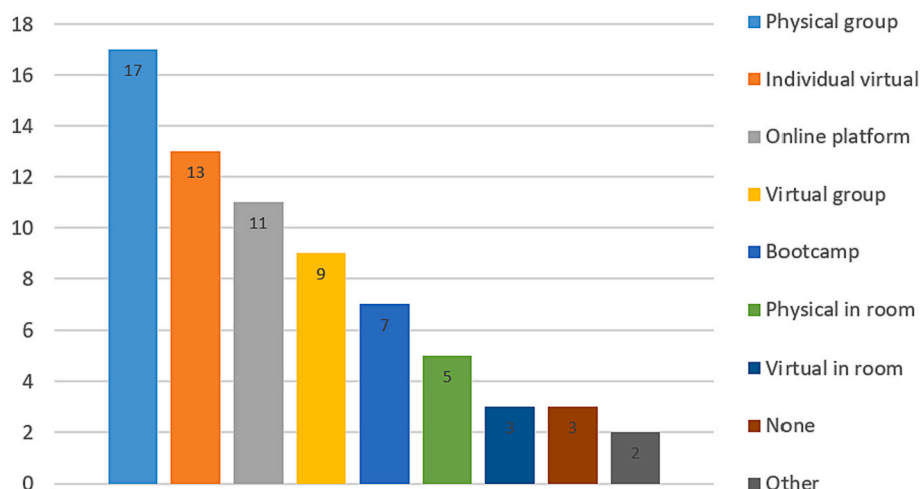


Fig. 4. The kind of training medical oncology professionals prefer to receive to deal with difficult consultations, showing that most professionals prefer a physical group training or an individual online training ($n = 45$).

can be helpful, e.g. informational support, but may also be less helpful, e.g. dominating/demanding behavior [26]. Our results suggest the need to integrate a third person in the model for SDM as well as training curricula and experiment with strategies to deal with difficult medical encounters such as those stated for triadic communication [26]. In addition, SDM is often defined with words that reinforce the positionality of active speaker versus passive recipient [27]. This may influence the perception of clinicians of SDM and their subsequent ability to adjust to proactive and dominant counterparts. To combat this challenge in complex, emotional and time-limited oncology consultations, a safe, comfortable digital training environment for clinicians may offer a solution to gain experience and repeatedly learn from common, specific difficult situations that the medical professional wants to practice. AI-supported virtual reality training using an avatar can provide intelligent feedback to the clinician on how to improve the conversation and thus improve clinical decision-making.

Workplace aggression research in the healthcare sector is mostly exploratory and descriptive in nature, resulting in huge variations in the prevalence and the definition of aggression [28]. Therefore, our study results on aggression in difficult encounters are in need of confirmation in a larger study. Currently, evidence on the effect of training and education [28] are of low evidence, but the need for intervention is still present given the positive correlation between perceived patient verbal aggression and healthcare professionals' emotional exhaustion [29].

With 29–62% of European citizens having a low health literacy [30], explainability and interpretability of medical information is essential. The 'decision helper' used in Denmark [31] elicits the amount of information the patient would like to receive, thereby personalizing the amount and complexity of information and thus facilitating comprehension. With equivalent consultation time, such an approach may benefit patient-provider communication with regard to content as well as logistics.

This study has limitations. Our analysis was exploratory and the sample size was small, limiting the ability to draw firm conclusions, e.g. on the effect of years of experience on the perceived difficulty. Also, the time between the last communication/medical encounter training and the actual patient encounter may be of effect on the perceived difficulty. In addition, data was retrieved anonymously, which may have facilitated an honest response, but also limits analysis on correlation with demographic variables and includes qualitative information, e.g. decisional conflict, addressing uncertainty and satisfaction.

4.2. Innovation

Although up to one third of the general consultations are considered difficult, there is no data available on the amount of consultations that are considered difficult within the field of oncology. Also, literature lacks insights into the kind of consultations that are considered difficult, which is a prerequisite to offer targeted communication training for medical professionals. While there is literature available on communication training in especially curricula development for medicine students and residents, there is a lack of current understanding of the needs of experienced medical oncology professionals with regard to the perception of difficult medical encounters and the kind of communication training preferred.

This study fosters innovation by describing the concrete medical encounters in need of support within daily oncology practice. It acknowledges current difficulties such as aggression and low health literacy, but also sometimes the third person in the (shared decision making) conversation. By addressing the sense of relatedness of what matters to oncology professionals, intrinsic motivation will help to develop and integrate specific education programs within organizations and curricula. This study provides tangible starting points to develop communication training that can help medical oncology professionals deal with difficult encounters in a supportive and effective manner.

4.3. Conclusion

Oncology professionals perceive a large number of their patient interactions as difficult medical encounters. Their need for practice-support in handling difficult medical encounters is preferred in either a physical group training or an individual virtual training. Support is especially evident when there is the presence of a dominant third person, aggression, and difficulty interpreting medical information.

CRedit authorship contribution statement.

Cheryl Roumen: Conceptualization, Methodology, Data collection, Data analyses, Interpretation, Writing – draft, review & editing. Claudia Offermann: Methodology, Data collection, Writing – review & editing. Danielle Eekers: Writing – review & editing. Marieke Spreeuwenberg: Conceptualization, Writing – review & editing. Rianne Fijten: Conceptualization, Writing – review & editing. We thank Liesbeth Boersma for bringing the authors in contact with the OncoZON network and reviewing survey questions. We thank all OncoZON participants who participated in the survey.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.pecinn.2023.100202>.

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