

Training the powerful: issues that emerged during the evaluation of a communication skills training programme for senior cancer care professionals

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'Connected' is the name of the national advanced communication skills training programme developed in 2008 for cancer care professionals in the NHS. A 3-day training course combining didactic and experiential learning elements is run by two facilitators with course participants expected to engage fully in simulated consultations with trained actors. In 2011, and as a result of participant feedback on the length of the course and increasing pressures on budgets and clinical time, the Connected team developed and piloted an alternative 2-day training course. Before its roll-out in 2012, Birmingham City University was commissioned to evaluate the effectiveness and quality of the 2-day course vis-à-vis the 'traditional' 3-day one. This article is written by the two evaluators and it discusses some of the issues that emerged during the evaluation. We broadly grouped these issues into two overlapping categories: the mandatory nature of the course and the different professional background and seniority of participants. In our discussion we consider the implications these issues have for communication skills training policy and practice and put forward suggestions for further research.

Keywords: communication, evaluation, European, education.

INTRODUCTION

Background

In their journey from learning about their condition to receiving good news about their response to treatment or making decisions about palliative care, cancer patients and their relatives/carers have to live with uncertainty and stress (Lancastle *et al.* 2011; Mitchell *et al.* 2011; Adams *et al.* 2012; Bache *et al.* 2012; Brennan *et al.* 2012).

For cancer care professionals, across different contexts and clinical settings, communicating effectively with patients and their carers is a crucial aspect of delivering high quality care (Fallowfield & Jenkins 1999; Alifrangis *et al.* 2011; Kai *et al.* 2011; Evans *et al.* 2012). Patients and their relatives/carers value good communication and understandably, 'good' communication can take many forms in cancer care. For example, a study by Jenkins *et al.* (2001) found that patients with different demographic characteristics had different preferences on receiving cancer care information, although the vast majority of them would like to receive a large amount of information regarding their condition and treatment. Undoubtedly, one aspect of professional cancer care is to provide patients with detailed information about their diagnosis, prognosis and treatment options. However, effective communication in cancer care extends beyond the mere provision of clinical

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information. A degree of patient involvement during communication is necessary, if cancer care professionals are to improve patients' quality of life and attend to their psychological and emotional care needs. On this, there is evidence to suggest that cancer patients' quality of life and care satisfaction can be predicted from the affective quality of their oncological consultation (Ong *et al.* 2000). However, we cannot interpret 'good' communication as the broad practice of encouraging patients to ask questions during their consultation or to talk about their emotional and social needs. The willingness of patients to discuss different aspects of their care (i.e. physical and emotional functioning and family and social life) can vary, and so can patients' and doctors' preferences of who should initiate discussions on health-related quality of life issues. Older people and people with lower educational attainments, for example have been shown to find it preferable that their doctor initiated such discussions (Detmar *et al.* 2000).

For cancer care professionals becoming a 'good' communicator is a process that involves professional judgment, experience as well as formal training. The context and content of communication in oncology can be themselves a barrier to effective communication between patients and cancer care professionals. Oncology nurses and doctors can at times restrict patients from asking questions and initiating discussions by using blocking behaviours and communication (Wilkinson 1991; Ford *et al.* 1996; Kruijver *et al.* 2000; Andersen & Adamsen 2001; Kennifer *et al.* 2009). Effective communication skills are not and should not be considered an automatic by-product of clinical/professional experience, but they are skills that can be acquired (Maguire 1990; Fallowfield *et al.* 2002; Moore *et al.* 2013). It has been also noted that, the absence of communication skills training on medical courses can have a negative impact on the way doctors 'learn' how to communicate with their patients (Maguire & Pitceathly 2002). It is therefore of paramount importance to offer cancer care professionals the opportunity to attend training that can help them deal with the difficulties of breaking bad news and managing stressful situations (Baile *et al.* 1999) and to communicate more effectively in general cancer care situations. A number of studies have found that post-qualification communication skills training can help cancer care professionals improve their communication techniques. In particular, nurses were found to make better wording choices during communication (Razavi *et al.* 2002) and to engage in behaviours that promoted patient-centeredness (Maguire *et al.* 1996). Similarly, oncologists who attended communication training were found to use open and focused questions that promoted patient-centeredness, to respond better to patients'

cues and to express empathy (Fallowfield *et al.* 2002). Further studies report similar improved communication outcomes for cancer care professionals who attended training (Faulkner 1992; Razavi *et al.* 1993; Lenzi *et al.* 2011) and a literature review by Merckaert *et al.* (2005) reveals that learner-centred, experiential and skill-focused communication training can be beneficial if delivered in small groups (of maximum of 6 participants) and if it lasts for a minimum of 20 h. Similar conclusions were reached by Barth and Lannen (2010) who opened up the debate about economic and feasibility issues in deciding the optimal length of communication skills training.

The NHS Cancer Plan (Department of Health 2000) and the NICE guidance on supportive and palliative care (NICE (National Institute for Clinical Excellence) 2004) made and reinforced respectively the commitment to build learner-centred, experiential communication skills training into the framework of continuing professional development and to make such courses available to all cancer care professionals. Between the years 2003–2007 the National Cancer Action Team was supporting a national training programme based on three variants that were developed by specialists in the field of communication skills training and cancer care. These specialists collaborated in order to materialise an intention to develop a unified national programme as this was expressed in the Cancer Reform Strategy (Department of Health 2007). In 2008, the unified national programme was launched with the name 'Connected' as a 3-day training course. The course is limited to a maximum of 10 participants with two facilitators leading its delivery. There is a mixture of teaching methods adopted throughout the course, including lectures and group discussions, and all participants are expected to engage fully in simulated consultations with trained actors, to role play, be filmed and to receive feedback from actors and other group members. Training sessions are structured around the needs of those participating, and so the content of each course can vary as it is the professionals themselves who decide which communication contexts they will explore during the course. Based on facilitators' accounts during our evaluation, participants usually explore one or more of the following communication contexts: Seeking informed consent; Breaking bad news; Communicating with colleagues; Communicating with relatives and handling conflict. Based on the numbers reported to us by the Connected team, between the years 2008–2011 around 11 500 professionals were trained, with priority given to core members of multidisciplinary teams (MDT). As it is mandatory for all core MDT members to meet the peer review process, participants can apply for professional development/study

leave in order to attend for training. The Cancer Outcomes Strategy (Department of Health 2011) reinforced the previous commitment to the public that all core members of the MDT who have direct contact with patients should receive communication skills training. In 2011, and as a result of participants' feedback on the length of the course and increasing pressure on budgets and clinical time, the Connected team developed and piloted a 2-day alternative course.

The 2-day alternative course

The new course has retained the core experiential element of the 3-day one (i.e. the role play sessions) but more didactic elements have been compacted and modified. For example, an 'Interactive Session' that is used in the 3-day course to explore skills that facilitate effective communication or to demonstrate behaviours that block communication is now delivered through the use of DVD clips. This session is still used by facilitators as preparation for role play. Prior to attending for training, participants of the 2-day course are required to start working on setting their own 'agenda' on what they want to explore/role play and to complete a pre-course workbook. In the 3-day course this takes place during the first day of training.

In total, six 2-day courses were run as pilot courses between July and October 2011 by six different local Cancer Networks across England. Before the 2-day course was rolled out in 2012, the Centre for Health & Social Care Research (CHSCR) of Birmingham City University was commissioned to complete an evaluation project to assess the effectiveness and quality of the 2-day course vis-à-vis the 'traditional' 3-day one. Based on the findings of our evaluation, we concluded that the new course had the potential to become as successful as the 3-day course, providing that participants were offered 'a suite of learning options' (as expressed by one of the facilitators we interviewed) to meet their learning needs, preferences and expectations. In this paper we discuss two dimensions of the 'suite of learning options'; the idea of offering participants the opportunity to choose whether they want to train in a multi-professional group or not, and whether to attend a 3-day or a 2-day training course.

Ethics statement

The Academic Peer Review and Sponsorship Committee in the Faculty of Health at Birmingham City University reviewed the evaluation project and approved indemnity insurance before a favourable ethical opinion was obtained from the Ethics Committee. Emails were sent by

the 'Connected' team to all training facilitators who had delivered both the 3-day and the 2-day course, inviting them to take part in the evaluation. All training facilitators who were approached were fully informed about the purpose of the project through detailed information sheets and consent forms which are available from the authors upon request. The information sheets made clear that participation was voluntary and that facilitators were free to withdraw from the evaluation project at any time without giving any reason and without getting penalised or affected in any way. Consent forms were signed by all training facilitators prior to their interviews. Before each interview commenced, facilitators were reminded of our intention to record the interview and of their right not to proceed with it if they no longer wished to.

The evaluation

The overall aim of the evaluation was to assess the effectiveness and quality of the new 2-day advanced communication skills training course. The main objectives were to:

- Examine the impact of the 2-day training course on participants' self-reported confidence to communicate in cancer clinical settings in 17 different contexts/areas of communication.
- Examine participants' opinions over different aspects of the 2-day training course and the learning materials used.
- Explore facilitators' perspectives of the strengths and limitations of the 2-day course vis-à-vis the 'traditional 3-day one'.
- Examine the integration of communicative competences within participants' scope of practice 3 months post training.

The evaluation took place between October 2011 and January 2012 and was based on mixed methods that included:

- Measuring participants' self-reported confidence to communicate in 17 different contexts/areas of cancer care communication using pre- and post-training questionnaires.
- Capturing participants' opinions over different aspects of the course and learning materials using the pilot course evaluation questionnaire.
- Eliciting course facilitators' perspectives of the strengths and limitations of the 2-day course in comparison to the 3-day one, using individual semi-structured telephone interviews.

- Examining participants' self-reported changes in communication practice(s) 3 months after the delivery of training using an online survey.

Sample

The 57 professionals who attended the six 2-day pilot courses acted as the sample for our evaluation. Of those, 44% were Doctors (of various ranks), 40% were Specialised Nurses, and 16% were classified as 'Other Professionals' (7% were Other Therapists and 9% were Care Managers). For the individual semi-structured telephone interviews we approached all 16 training facilitators who had, at the time of the evaluation, delivered both 2- and 3-day courses. Of those, 12 agreed to be interviewed for the evaluation, and 33 of the 57 professionals who attended the 2-day pilot courses also completed the online survey on how communicative competences developed during training were integrated into their practice 3 months post training.

DATA COLLECTION METHODS

Self-reported confidence questionnaires

Communication training experts of the Connected team designed and piloted the pre- and post-training questionnaires that measured levels of confidence to communicate in 17 different contexts. These instruments measured confidence at an ordinal level and they asked professionals to rate, pre- and post-training, how confident they were communicating in these 17 communicative contexts, using a 10-point Likert scale. Data collection was carried out by the Connected team during the pilot training sessions.

'Pilot course evaluation' questionnaire

Communication training experts of the Connected team designed and piloted questionnaires that measured, at ordinal and nominal levels, participants' opinions over different aspects of the course and the learning materials used. These instruments asked participants to rate certain elements of course using either a 10-point Likert scale or a YES/NO choice. Data collection was carried out by the Connected team during the pilot training session.

Facilitators' perspectives

Twelve individual semi-structured telephone interviews were held with 12 training facilitators in order to elicit

their perspectives of the relative strengths and limitations of the 2-day course. The interviews were audio recorded.

Online survey

The Connected team designed and piloted an online survey that measured, at a nominal level, participants' changes in communication practices three months after completing the training. The survey asked participants to indicate whether their communication practices, in different areas of cancer care, have changed as a result of completing the training using a YES/NO choice. The survey also contained open-ended questions, but only a few participants chose to answer these.

DATA ANALYSIS METHODS

Self-reported confidence questionnaires

Responses were analysed using SPSS (v17) software. Our descriptive analysis focused on differences in participants' mean levels of confidence on each of the 17 items of the questionnaires (Table 1 for the questionnaire items). The analysis was carried out per professional role. In examining whether the changes observed were statistically significant, Wilcoxon signed rank sum tests were run for pre- and post-training scores. The level of significance was set at $P = 0.05$.

'Pilot course evaluation' questionnaire

Responses were analysed using SPSS (v17) software. Our descriptive analysis focused on calculating total counts and percentages for each item on the questionnaire (see findings section for the answers to these items).

Facilitators' perspectives

The interviews were transcribed and analysed using framework analysis (Ritchie & Spencer 1994), and Rabiee's (2004) guidelines. During the analysis we identified emerging themes and sub-themes from the transcribed data. Transcripts were read independently by both members of the evaluation team and analysis was systematic, sequential and verifiable. This provided a trail of evidence and increased the extent of dependability, consistency and conformability of data, important issues for assessing the quality of qualitative data analysis (Spencer *et al.* 2003; Denzin & Lincoln 2005). Similarly to Srivastava and Thomson (2009), we found that this particular approach to data analysis enabled us to maintain

not only the quality standard and rigour for analysing qualitative data, but also provided a flexibility to work with pre-determined questions and within the strict limited time frame of the evaluation. The interview extracts used in this paper illustrate some of the main themes identified during data analysis. To ensure anonymity, during transcription and data analysis, all respondents were given two random letters of the alphabet and all details that could lead to their identification were removed.

Online survey

Our descriptive analysis focused on calculating total counts and percentages for each item on the survey (see findings section for the answers to these items). No distinctions were made per professional role.

FINDINGS OF THE EVALUATION

Confidence to communicate

Following the 2-day course, participants' self-reported levels of confidence to communicate had increased in all 17 different contexts/areas of communication presented in the questionnaire. For doctors, all changes in pre- and post-training scores were statistically significant (see Table 1).

For the Specialised Nurses and Other Professionals, some changes in scores were not significant. These were in communication areas that these groups may not have practiced. For example, Specialised Nurses and Other Pro-

fessionals may not have had to 'Tell Patients with a Good/Poor Prognosis that they have Cancer' (see Tables 2 and 3).

Similar differences were also noted in participants' pre-training scores of confidence to communicate in different communicative contexts (see Fig. 1).

Prior to training, doctors reported to be more confident to (1) recognise and acknowledge patient cues; (2) tell patients with a good prognosis that they have cancer; and (3) obtain informed consent from patients. Doctors felt less confident to (1) challenge colleagues about their behaviour; (2) tell patients with a poor prognosis that they have cancer; (3) tell patients that they have a recurrence of their cancer; and (4) discuss psychological problems with patients. On the other hand, and prior to training, specialised nurses reported to be relatively more confident to (1) discuss psychological problems with patients and to tell patients the most likely effects of their treatment.

Differences among different professionals groups were also noted in their self-reported changes in levels of confidence (changes in median values pre- and post-training) with the Other Professionals group reporting the largest increase in their confidence scores (see Fig. 2).

Evaluating the course

Overall, participants evaluated the course positively. Eighty-seven per cent of them felt that the pacing of the course was 'Just Right'. Seventy per cent of participants felt that the length of the course was 'Just Right', while 21% of them found it 'Too Long'. Seventy-three per cent of participants found that the Workbook (pre-course preparation) is 'Definitely' essential in optimising

Table 1. Differences in doctors' ($n = 25$) pre- and post-training self-reported levels of confidence to communicate in cancer clinical contexts (table taken from Rabiee & Bibila 2012, p. 24)

Question item no.	Communication context description	Paired samples test statistic (Z)	Significance (P)
1	Structuring an assessment interview effectively	-3.402	0.001
2	Recognising & acknowledging patient cues	-2.932	0.003
3	Exploring patient cues	-2.872	0.004
4	Working with the patient's agenda before integrating practitioner's own	-3.071	0.002
5	Handling strong emotions (anger, anxiety, etc.)	-2.913	0.004
6	Identifying patients' or relatives' concerns	-3.424	0.001
7	Challenging patients/relatives about their behaviour	-3.169	0.002
8	Challenging colleagues about their behaviour	-3.863	0.000
9	Telling patients with a good prognosis that they have cancer	-3.241	0.001
10	Telling patients with a poor prognosis that they have cancer	-2.857	0.004
11	Telling patients that they have a recurrence of their cancer	-3.089	0.002
12	Telling patients that you are replacing active therapy with symptomatic care only	-2.580	0.010
13	Discussing psychological problems with patients with cancer	-3.746	0.000
14	Discussing sexual issues with patients with cancer	-2.425	0.015
15	Discussing clinical trials with patients with cancer	-3.411	0.001
16	Obtaining 'informed' consent from patients with cancer	-3.157	0.002
17	Telling patients the most likely effects of treatment	-3.044	0.002

Table 2. Differences in nurses' ($n = 23$) pre- and post-training self-reported levels of confidence to communicate in cancer clinical contexts (table taken from Rabiee & Bibila 2012, p. 25)

Question item no.	Communication context description	Paired samples test statistic (Z)	Significance (P)
1	Structuring an assessment interview effectively	-3.371	0.001
2	Recognising & acknowledging patient cues	-2.964	0.003
3	Exploring patient cues	-3.035	0.002
4	Working with the patient's agenda before integrating practitioner's own	-3.409	0.001
5	Handling strong emotions (anger, anxiety, etc.)	-2.329	0.020
6	Identifying patients' or relatives' concerns	-2.995	0.003
7	Challenging patients/relatives about their behaviour	-3.84	0.000
8	Challenging colleagues about their behaviour	-3.099	0.002
9	Telling patients with a good prognosis that they have cancer	-3.022	0.008
10	Telling patients with a poor prognosis that they have cancer	2.890	0.004
11	Telling patients that they have a recurrence of their cancer	-3.099	0.002
12	Telling patients that you are replacing active therapy with symptomatic care only	-2.848	0.004
13	Discussing psychological problems with patients with cancer	-3.612	0.000
14	Discussing sexual issues with patients with cancer	-3.612	0.000
15	Discussing clinical trials with patients with cancer	2.534	0.011
16	Obtaining 'informed' consent from patients with cancer	-3.142	0.002
17	Telling patients the most likely effects of treatment	-3.142	0.063

Table 3. Differences in other professionals' ($n = 9$) pre- and post-training self-reported levels of confidence to communicate in cancer clinical contexts (table taken from Rabiee & Bibila 2012, p. 26)

Question item no.	Communication context description	Paired samples test statistic (Z)	Significance (P)
1	Structuring an assessment interview effectively	-2.264	0.024
2	Recognising & acknowledging patient cues	-2.687	0.007
3	Exploring patient cues	-2.687	0.007
4	Working with the patient's agenda before integrating practitioner's own	-2.714	0.007
5	Handling strong emotions (anger, anxiety, etc.)	-2.660	0.007
6	Identifying patients' or relatives' concerns	-2.549	0.011
7	Challenging patients/relatives about their behaviour	-2.388	0.017
8	Challenging colleagues about their behaviour	-2.207	0.027
9	Telling patients with a good prognosis that they have cancer	-1.841	0.060
10	Telling patients with a poor prognosis that they have cancer	-1.841	0.066
11	Telling patients that they have a recurrence of their cancer	-1.633	0.102
12	Telling patients that you are replacing active therapy with symptomatic care only	-2.041	0.041
13	Discussing psychological problems with patients with cancer	-2.014	0.044
14	Discussing sexual issues with patients with cancer	-2.060	0.039
15	Discussing clinical trials with patients with cancer	-1.841	0.066
16	Obtaining 'informed' consent from patients with cancer	-2.232	0.026
17	Telling patients the most likely effects of treatment	-2.014	0.044

learning on the course with 23% finding that it is 'Perhaps' essential. Seventy-five per cent of participants stated that there would be no benefits of having an extra day of training, 15% would find a 3-day course beneficial and 10% of the participants did not give an opinion on the benefit of having an extra day.

Training facilitators' perspectives

The analysis of the interview data suggested that training effectiveness depends more on participants' attitudes to communication skills training, their preparation before the course, their learning needs and preferences and existing

knowledge/skills on effective communication rather than on the length of the training.

According to all facilitators interviewed, a striking difference between the two courses is the replacement of the 'Interactive Session' of Day 1 with DVD clips. A number of facilitators felt that this change makes it challenging to explain to participants what 'facilitating skills' and 'blocking behaviours' are within the time constraints this fast-paced course places on facilitators. Further, facilitators felt that the 2-day course places greater demands on participants. Participants not only need to prepare for training by engaging in background reading and completing their pre-course workbook, they also need to be well

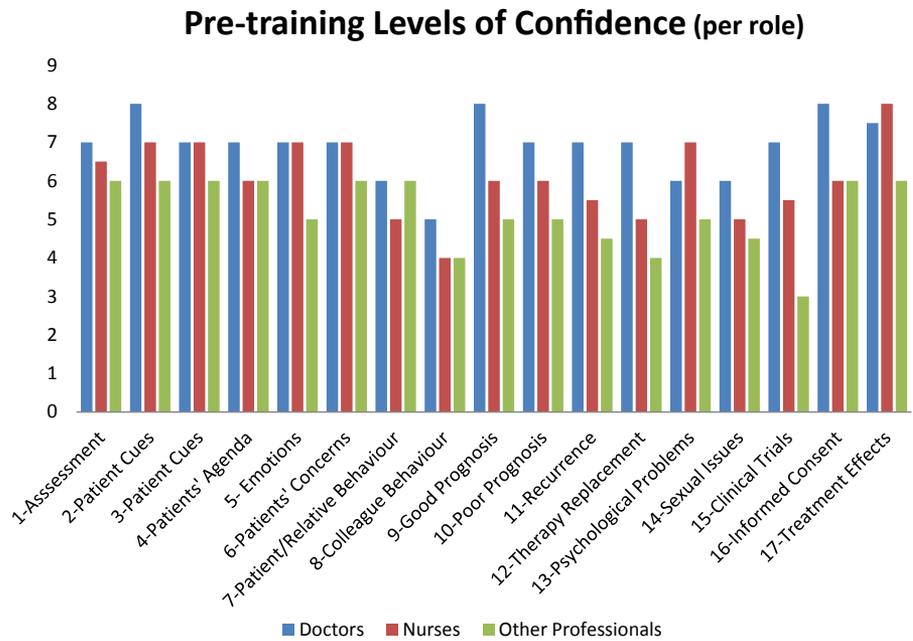


Figure 1. Pre-training self-reported levels of confidence (median values) to communicate in cancer clinical contexts (per professional role; graph taken from Rabiee & Bibila 2012, p. 22).

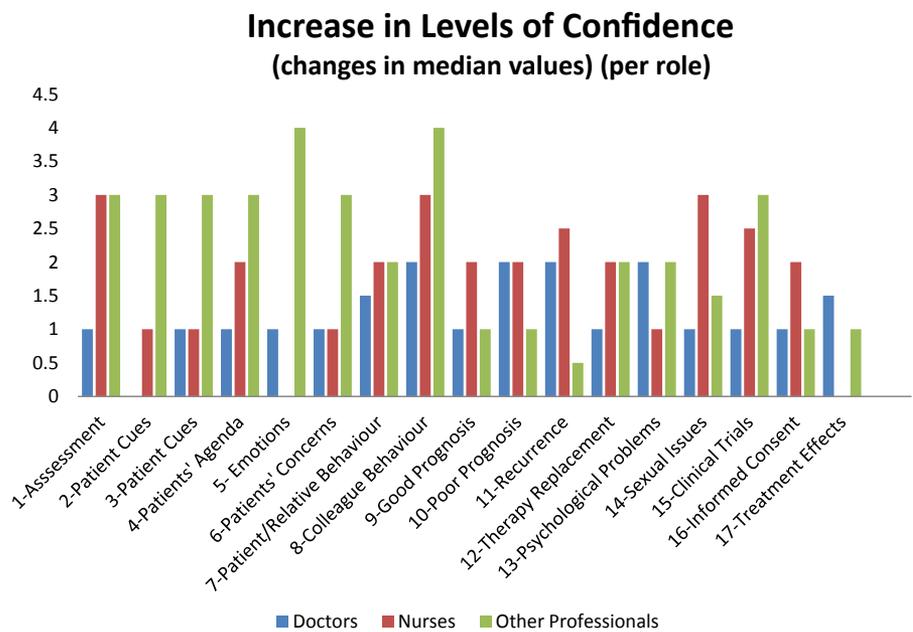


Figure 2. Self-reported changes in levels of confidence (median values) to communicate in cancer clinical contexts (per professional role; graph taken from Rabiee & Bibila 2012, p. 23).

motivated and able to concentrate for long periods of time during training. Facilitators expressed the belief that the fast pacing was suitable for certain professional groups (i.e. surgeons) and individuals with prior theoretical knowledge on effective communication and existing strong communication skills. Similarly, the 2-day course could suit the teaching style of certain facilitators, although it was commonly believed that it is unlikely to suit inexperienced facilitators. More than half of the facilitators believed that the 2-day course could help participants to be more open-minded about the training and to become

less resistant and 'negative', knowing that they will only take two rather than three days off clinical practice. A couple of facilitators highlighted that one of the risk of the 2-day course is that, if such reluctant participants are part of the group, there is no time for facilitators to deal with them. Facilitators also highlighted that the 2-day course fosters further potential risk to learning due to its shorter length, faster pacing and intensity. These risks were associated with setting a limited 'agenda', the rigidity and high levels of prescription of the course and having a 'low energy' group. For a detailed account of the evaluation, its

Table 4. Areas of communication in which changes of communication practice were noted 3 months post training (table taken and adapted from Rabiee & Bibila 2012, p. 34)

Item no.	Communication areas (changes in)	Yes*	No*
1	Increased confidence when communicating with patients/ relatives	94%	6%
2	Increased confidence when communicating with colleagues	73.5%	26.5%
3	Changes in clinical practice	94%	6%
4	Telling a patient their cancer has progressed on treatment	68%	32%
5	Coping with angry patients/relatives	83%	17%
6	Managing withdrawn/emotionless patient	77%	23%
7	Dealing with a patient with unrealistic expectations	83%	17%
8	Managing patients in denial	70%	30%
9	Managing a family who do not want 'conventional treatment'	43%	57%
10	Giving complex information about clinical trials	36%	64%
11	Managing relatives wanting to withhold the truth from a patient	64%	36%
12	Managing maintaining hope when moving from curative to palliative settings	54%	46%
13	Communicating with a difficult colleague	60%	40%
14	Managing colleagues who give unrealistic expectations	50%	50%

*Percentages have been rounded.

scope, methodology and findings please Rabiee and Bibila (2012).

Integrating communicative competences in practice

More than 70% of the 33 participants who completed the online survey reported a change in their practice for 7 out of 14 contexts/areas of communication presented in the survey questionnaire. The greatest changes were noted in the areas of: 'Communicating with Patients' and 'Changes in Clinical Practice'. Similarly to the findings of the 3-day programme evaluation, less than 50% of participants changed their practices when it came to 'Giving Complex Information about Clinical Trials'. Other areas of communication practice in which participants did not seem to make changes were 'Managing a Family who do Not Want "Conventional Treatment"' and 'Managing Colleagues who Give Unrealistic Expectations' (see Table 4).

SUMMARY OF THE EVALUATION AND LIMITATIONS

Time restrictions and sample size limitations, as well as our reliance on secondary data and the design of the study, constrained us from making a direct comparison between the 3-day and the 2-day course. Although the small sample sizes did not allow us to use the questionnaire findings as a basis for generalisation, the self-reported confidence questionnaires provided us with valuable data and insights that were used in combination with facilitators' interview data to look at course effectiveness per professional role.

Capturing facilitators' perspectives on the relative strengths and limitations of the 2-day course illuminated important dimensions of communication skills training. For example, issues of determining 'optimal' length for

training and clinicians' resistance to take two days off clinical practice and the advantages and limitations of training groups of different professionals and different status together.

Both in our evaluation and in the previous evaluation of the 3-day course that was carried out by the 'Connected' team, effectiveness of training was seen as the increase in practitioners' confidence to communicate in cancer clinical settings in 17 different contexts/areas of communication. The levels of confidence measured were self-reported and this in its turn raises questions about the limitations of using self-assessment (Kruger & Dunning 1999; Davis *et al.* 2006; Lipsett *et al.* 2011). The same limitation applies to the 3-month post-training survey.

DISCUSSION – ISSUES ARISING FROM THE EVALUATION

The mandatory nature of the course

Depending on the type of cancer they treat and the type of Multi Disciplinary Team (MDT), that is, either local or regional/specialist, membership of MDTs differ. For example, a breast cancer MDT will have among its core members a surgeon, a breast care nurse, a pathologist, a radiologist, an oncologist and a radiographer. Core membership for head/neck cancer extends to include a dietician and a speech and language specialist. Attendance of the advanced communication skills training is mandatory for all core members of the MDT who have direct contact with patients. This mandatory nature of the course was one of the key themes that emerged during the analysis of the interview data. Many of the course facilitators that were interviewed commented on the resistance and negativity they sometimes need to face up to when dealing

with participants who cannot see a 'need' for completing the training course. Such participants, usually highly experienced Consultants, were described as being defensive and disruptive, often displaying cynicism about the benefits of the training.

During the evaluation of the 2-day training course we often reflected on issues that felt outside the scope of the evaluation itself. For example, we contemplated on relatively recent developments in health care such both the successful and less successful attempts to overturn the medical model, the 'weakening' of power certain health care professionals once possessed and the placement of the 'patient-consumer' at the centre of care. We also reflected on the standards of care these developments set, for professional-patient interactions and information sharing, decision making and involvement in care (Ong *et al.* 1995; Quill & Brody 1996; Charles *et al.* 1999). We questioned how deeply rooted are the beliefs that communication skills are the by-product of clinical experience, or an unnecessary part of medical education (Fadlon *et al.* 2004), or an innate ability that professionals can either underestimate or overconfidently judge that they possess (Turner *et al.* 2011).

The interview data we obtained from facilitators brought to the surface the links between resistance to train, clinical time/target pressures and professional roles and seniority. We return to discuss the benefits and limitations of training participants in mixed groups of seniority and professional roles in the second part of this section. Here it is worth noting that differences among professional groups can extend to their attitudes to communication skills training, with nurses being more in favour of mandatory communication skills training than doctors (Payne *et al.* 2009). During the evaluation we found that the perceived training needs of distinct professional groups can also vary depending on the amount and type of patient contact they have. On this, Payne *et al.* (2009, p. 24) write that, there is a view that certain medical specialist such as radiologists and pathologists 'who may have little patient contact and are unlikely to be the person delivering bad news to patients and their relatives' should not have to undertake communication skills training. As we have pointed out, communication in cancer care is multi-faceted and it extends beyond providing clinical information to the patient and/or breaking bad news. In accounting for the varied and complex nature of communication in cancer care, the Connected programme offers professionals the flexibility of choosing what areas of communication they would like to cover during their training and the role plays. However, we cannot assume that increased flexibility to choose the content of training

sessions is synonymous with participants giving their integral attention and cooperation during training. Nearly all of the facilitators interviewed expressed the belief that one of the potential advantages of the 2-day course is to minimise the resistance of participants, especially doctors, for taking 2 rather than 3 days out of clinical practice in order to attend for training. Interestingly, the hope that participants will be more motivated to attend a shorter course and therefore facilitators will have to face less negativity when dealing with reluctant participants was counterbalanced by the pessimistic view that 'even taking 2 days out of clinical practice is challenging' (Facilitator AF) and 'reluctant delegates will always find something else to complain about' (Facilitator BF). After all, 21% of the participants who evaluated the 2-day course felt that even two days was too long for this type of training. As we did not have the opportunity to explore participants' view about the length of the course, we cannot be sure whether those participants had already attended similar types of training or whether they had previous theoretical and/or practical knowledge on communication techniques or whether they were resistant to take two days off clinical practice to attend 'soft-skills' training.

According to nine out of 10 facilitators that we interviewed, the fast-paced 2-day course does not give them the time to screen for participant resistance or 'to deal with difficult participants and have a one-to-one (session) with them' (Facilitator JM). This, according to the facilitators, can be detrimental to learning for the whole group. This is an issue of great importance, considering that participants need to attend for the 2-day course well-prepared. This need was also recognised by the participants themselves as 73% of those who completed the 'Pilot Course Evaluation' questionnaire stated that completing the Workbook (pre-course preparation) is essential to optimising learning on the 2-day course.

An issue that deserves close attention is the effectiveness, and cost-effectiveness, of compulsory communication skills training. Moore *et al.* (2004) carried out a systematic literature review on the effectiveness of communication skills training in changing cancer care professionals' behaviour with regard to communication/interaction with patients. The authors suggested that 'further research is required to assess the long-term efficacy of compulsory training' as the beneficial effect on behaviour change observed could be attributed to the 'enthusiasm and/or skill of the facilitators and/or participants' (Moore *et al.* 2004, p. 2). Although we return to briefly discuss, in the last part of the paper, the peculiarity of conceiving interventions on human communication in

terms of efficacy and effectiveness, the main question here is how beneficial can compulsory training be? For cancer care professionals who attend solely as part of the peer review process, for those who are neither 'enthusiastic' about communication skills training nor adequately prepared. How beneficial can it be mixing resistant participants with professionals who indeed attend training with the aim to improve their communication skills? Similarly, we cannot help but wonder about the options of cancer care professionals who recognise that they have little prior theoretical knowledge of effective communication skills and/or feel they would benefit from attending a 3-day course.

We strongly believe that the effectiveness of communication skills training partly depends on offering participants what one of the facilitators called '*a suite of learning options*'. This includes the choice of selecting to participate in either the 3-day or the 2-day course. Our suggestion in its turn raises the question of what benefits and limitations cancer care professionals attribute to courses of different length (2 and 3 days). As one facilitator pointed out:

Whether they [participants and NHS Trusts] have enough insight to decide, is another issue. . . . and Trusts are also more likely to release people for 2 days if this was an option available. (Facilitator JC)

Overstretched clinicians working towards meeting targets and shortening their waiting lists may be more inclined to attend the shorter training course, irrespectively of prior knowledge and existing skills. The facilitators we interviewed expressed a hope that all participants attending the 2-day course will be well-prepared, motivated and with a willingness to learn.

While we continue to operate within a framework of marketisation of health services and 'mimic consumerism' (Klein 2001) and with the NHS principles of managerialism and commodification of health and professional skills (Henderson & Petersen 2002; Pollock 2005; Cribb 2008) gaining dominance and acceptance, the risk of turning communication skills training into a box ticking exercise will always be present. The practical reality for participants and facilitators is that the mandatory nature of the course, combined with an increasing pressure on clinical times, can have enormous implications on the 'safe' delivery of the 2-day course. We share, with a number of facilitators, the belief that if the new course is to be effective, then the Connected team may need to develop a unified policy on how facilitators can deal with reluctant and negative participants on the first day of training. As facilitator JC has put it, in the fast-

paced 2-day course it may be a case of telling resistant participants 'to overcome their cynicism or go home'. In discussing issues of 'negativity' and 'resistance' to communication skills training we felt that it is also important to take into account and discuss the differences in professional background and seniority of participants.

The different professional background and seniority of participants

As we explained in the sub-section above, MDT membership varies and so did the professional background and seniority of participants who attended the 2-day pilot training programmes. A positive finding of our evaluation was the increase in participants' self-reported confidence to communicate in 17 different contexts/areas of cancer care communication. For doctors all changes in pre- and post-training scores were statistically significant, while changes that were not significant were noted only in professional groups (i.e. Specialist Nurse and Other Professionals) that did not practice in certain contexts (telling patients with a good/poor prognosis that they have cancer or discuss clinical trials with patients). One of the findings that is worth looking at more closely is the difference in confidence levels, both pre- and post-training, reported by the different professionals groups. As we presented in the findings section, doctors reported to be less confident to discuss psychological problems with patients, than recognising and acknowledge patient cues, while for nurses the reverse is the case.

The possibility of professionals underestimating or overestimating their communication skills and abilities is an issue that takes us back to one of the limitations of our evaluation. In evaluating the effectiveness of the 2-day Connected course, we relied on participants self-reporting their confidence to communicate pre- and post-training. It is therefore likely that participants would not only 'want to be seen making some progress' (Facilitator BF), but also that they would reflect in their scores 'their enthusiasm about role playing' (Facilitator NK) and about the training as a whole. As part of the pilot course evaluation questionnaire, participants gave positive feedback about the training and one could assume that Doctors, a professional group that reported to feel less comfortable engaging in communication tasks involving psychological support, expressed their enthusiasm or the desire to make (and be seen to make) progress by inflating in this way their post-training confidence scores. In a contrary manner, one could assume that nurses' scores in certain communication areas, such as handling strong emotions, showed the least increase in confidence scores (as reflected in median

values, see Fig. 2), as a result of gaining greater awareness of one's inability to manage certain communicative situations.

Payne *et al.* (2009) also found differences in the self-rating of communication skill and ability between members of different professional groups. These differences and the findings of our evaluation signalled to us the potential need for different professional groups to explore and role play different contexts/areas of communications. One of the key themes that emerged during the analysis of the interview data was the time restrictions the new 2-day course puts on facilitators and participants and the limited opportunity groups have to explore/role play a wider range of communication contexts/areas. In that respect, the 2-day course may be delivered more effectively if a professional role-tailored approach is followed. Here it is worth recalling the origins of the 'Connected' programme and how communication skills training was originally developed for and delivered to homogeneous groups of professionals. Between the years 2003–2007 the national training programme was actually based on three variants developed by distinct specialists in the field of communication skills training and cancer care, namely Professors Lesly Fallowfield, Peter Maguire and Amanda Ramirez and Dr. Susie Wilkinson. It was in 2008 that a unified national programme was launched with the brand name 'Connected', an attempt to try and to 'combine' the three variants.

According to a number of facilitators that took part in the evaluation, the professional mix as well as the status of participants can influence significantly the dynamics of 'agenda' setting and group decisions on which communication contexts/areas are to be explored and role played during training. Facilitators further commented on the difficulty some senior practitioners, mainly consultants, had on 'opening up' to role play and receiving feedback from less senior medical staff. At times, this can amplify the resistance and negativity senior clinicians are showing, making the facilitation of certain training sessions particularly challenging. As one of the facilitators commented,

We used to spend a lot of time on allocating who does what, working with the group with professionals of different power status, explaining why mobile phones need to be off. This clearly can't happen on the 2-day course. (Facilitator SA)

It can be argued that a multidisciplinary approach to training fosters a number of risks to learning relating to the different learning needs of participants, different attitudes to compulsory training as well as the power imbalances

stemming from their different status and seniority (Turner *et al.* 2011). In Payne *et al.*'s (2009) study, doctors expressed greater preference for the training to be provided for separate professional groups. In our evaluation, we found that the 2-day course seemed to suit certain homogeneous professional groups better than others for reasons relating to job design. The pattern of 'starting the day early, finishing late' (Facilitator YF) seemed to chime well with the work pattern of doctors, while a homogenous group of 10 surgeons were reported to have coped better with the fatigue of longer days, the faster pace of training and lengthy periods of intense concentration during the course.

On the other hand, there were findings in our evaluation that highlighted the benefits of adopting a multidisciplinary approach to communication skills training. Both doctors and specialist nurses reported that the context/area of communication in which they felt less confident was 'Challenging Colleagues about their Behaviour'. This context of communication was also identified as the most problematic one in the 3-day evaluation previously undertaken by the 'Connected' team. Interestingly, this is the context/area of communication in which the largest increase in confidence was noted post training for all three professional groups. As one of the facilitator commented, multidisciplinary training helps participants 'to understand each other's roles' (Facilitator AF). A key parameter in evaluating communication skills training is sustainability of change in behaviour and one of the limitations of our evaluation was that it did not fully address this. The open-ended questions of the online survey that was administered 3 months post training aiming to capture the extent to which course participants integrated communicative competences in their areas of practice, and the nature of this integration, was completed only by few participants. Further, the design of the survey did not allow us to make the distinction between those participants who, in their everyday practice, engaged in all or in some of the communicative areas described in the survey questionnaire, thus increasing the non-response bias. However, we can be justified to think that all cancer care professionals work in teams and it was encouraging to see that 73.5% of the respondents reported that 3 months post training they continued to experience changes in their confidence to communicate with colleagues.

At this point we want to return to the suggestion of offering course participants 'a suite of learning options' which currently includes the choice of selecting to train in separate professional groups or as a multidisciplinary group. Although, and as Turner *et al.* (2011) argue, the 'one-size fits all' approach to communication skills training cannot be an effective approach, the question is who is

in the best position to decide on and evaluate the 'right' mix of course length (i.e. 3-day VS 2-day) and composition (i.e. multidisciplinary VS single professional groups)? We believe that such decisions reflect the normative dimension of offering training to healthcare professionals in order to improve patient experience and the quality of health care. They also reflect the inherent judgment dimension of making decisions about 'achievements, about expectations, about the effectiveness and value' of what we, as adult educators and trainers do (Rogers 1986, p. 220).

Final thoughts

Having mentioned the normative dimension of communication skills training for cancer care professionals we felt the need to make a brief comment relating to some of the unexamined 'gaps' found in the notions of effective communication and effective communication training. Both Moore *et al.* (2004) and Barth and Lannen (2010) point out the need to assess the long-term efficacy of compulsory training and they uncover a lack of evidence on 'what works' in terms of the different communication skills training components, the kind of evidence that would be useful to course designers and evaluators. There is indeed a certain peculiarity inherent in conceiving training courses on human communication in terms of effectiveness and efficacy. Conceiving them in terms of determining training effectiveness prior to even cancer care professionals engaging with the course and re-entering professional practice as implied by Schofield and Butow's (2004) framework. Efficacy is concerned with achieving the desired results under ideal circumstances, but basing communication training programmes on the notion of the 'ideal' practitioner-communicator seems to be both utopian and unrealistic. Effectiveness on the other hand might seem a more practical concern as it addresses the benefits of communication training under 'real world' communicative situations. Yet again, and if we are to take into account sociocultural aspects of communication and the varied contexts in which cancer care communication takes place, the question arising is effective by whose standards, in other words effective for what, whom and under which circumstances? Barth and Lannen (2010, p. 1035) write that 'the ultimate indicator of whether Communication Skills Training is useful in improving communication and patient interaction is the impact on the patient him- or herself.' However as they point out, very few studies have been concerned with the addressing the gap between communication skills training and impact on professional practice and patients.

CONCLUSION AND FURTHER RESEARCH

The notion of 'effectiveness' in communication and communication training is complex in its own right. Moving beyond the surface of questions pertaining communication effectiveness, efficacy of training (Barth & Lannen 2010) and sustainable behaviour change (Moore *et al.* 2004), there is the question of whose standards are to be selected for designing, delivering and evaluating communication skills training in cancer care.

In this paper we discussed some of the issues that emerged during an evaluation of a 2-day communication skill training for senior cancer care professionals. We broadly grouped these issues into two overlapping categories: The mandatory nature of the course and the different professional background and seniority of participants comprising the training groups. Professionals with an interest in cancer care communication skill training should give these issues further attention. The value of our paper lies in bringing up for discussion a number of issues in communication skills training for senior cancer care professionals that warrant further attention. We see the gap between efficacy and effectiveness of training and the gap between theory and practice to resemble the leap between describing the 2-day training course and evaluating its effectiveness. How, and the extent to which, these gaps can be bridged depends on one's philosophical and theoretical stand.

Based on our discussion in this article, we believe that further research may be valuable in order to explore in more depth senior cancer care professionals' views on the value of mandatory communication skills training. It will also be of interest and value to examine patients', carers' and professionals' perspectives on and experiences of effective communication in the 17 communication contexts/areas the Connected course covers.

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REFERENCES

- Adams E., Boulton M., Rose P.W., Lund S., Richardson A., Wilson S. & Watson E.K. (2012) A qualitative study exploring the experience of the partners of cancer survivors and their views on the role of primary care. *Supportive Care in Cancer* **20**, 2785–2794.
- Alifrangis C., Koizia L., Rozario A., Rodney S., Harrington M., Somerville C., Peplow T. & Waxman J. (2011) The experiences of cancer patients. *QJM: Monthly Journal of the Association of Physicians* **104**, 1075–1081.
- Andersen C. & Adamsen L. (2001) Continuous video recording: a new clinical research tool for studying the nursing care of cancer patients. *Journal of Advanced Nursing* **35**, 257–267.
- Bache R.A., Bhui K.S., Dein S. & Korszun A. (2012) African and Black Caribbean origin cancer survivors: a qualitative study of the narratives of causes, coping and care experiences. *Ethnicity and Health* **17**, 187–201.
- Baile W.F., Kudelka A.P., Beale E.A., Gloger G.A., Myers E.G., Greisinger A.J., Bast R.C., Jr, Goldstein M.G., Novack D. & Lenzi R. (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.
- Barth J. & Lannen P. (2010) Efficacy of communication skills training courses in oncology: a systematic review and meta-analysis. *Annals of Oncology* **22**, 1030–1040.
- Brennan J., Gingell P., Brant H. & Hollingworth W. (2012) Refinement of the distress management problem list as the basis for a holistic therapeutic conversation among UK patients with cancer. *Psycho-Oncology* **21**, 1346–1356.
- Charles C., Gafni A. & Whelan T. (1999) Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. *Social Science and Medicine* **49**, 651–661.
- Cribb A. (2008) Organizational reform and health-care goods: concerns about marketization in the UK NHS. *Journal of Medicine and Philosophy* **33**, 221–240.
- Davis D., Mazmanian P.E., Fordis M., Van Harrison R., Thorpe K.E. & Perrier L. (2006) Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. *JAMA: The Journal of the American Medical Association* **295**, 1094–1102.
- Denzin N.K. & Lincoln Y.S., eds (2005) *The Sage Handbook of Qualitative Research*. Sage, Thousand Oaks, CA, USA.
- Department of Health (2000) *NHS Cancer Plan*. The Stationery Office, London, UK.
- Department of Health (2007) *Cancer Reform Strategy*. The Stationery Office, London, UK.
- Department of Health (2011) *Improving Outcomes: A Strategy for Cancer*. The Stationery Office, London, UK.
- Detmar S.B., Aaronson N.K., Wever L.D., Muller M. & Schornagel J.H. (2000) How are you feeling? Who wants to know? Patients' and oncologists' preferences for discussing health-related quality-of-life issues. *Journal of Clinical Oncology* **18**, 3295–3301.
- Evans J., Ziebland S. & Pettitt A.R. (2012) Incurable, invisible and inconclusive: watchful waiting for chronic lymphocytic leukaemia and implications for doctor-patient communication. *European Journal of Cancer Care* **21**, 67–77.
- Fadlon J., Pessach I. & Toker A. (2004) Teaching medical students what they think they already know. *Education for Health* **17**, 35–41.
- Fallowfield L. & Jenkins V. (1999) Effective communication skills are the key to good cancer care. *European Journal of Cancer* **35**, 1592–1597.
- Fallowfield L., Jenkins V., Farewell V., Saul J., Duffy A. & Eves R. (2002) Efficacy of a Cancer Research UK communication skills training model for oncologists: a randomised controlled study. *Lancet* **359**, 650–656.
- Faulkner A. (1992) The evaluation of training programmes for communication skills in palliative care. *Journal of Cancer Care* **1**, 75–78.
- Ford S., Fallowfield L. & Lewis S. (1996) Doctor-patient interactions in oncology. *Social Science and Medicine* **42**, 1511–1519.
- Henderson S. & Petersen A., eds (2002) *Consuming Health. The Commodification of Health Care*. Routledge, London, UK.
- Jenkins V., Fallowfield L. & Saul J. (2001) Information needs of patients with cancer: results from a large study in UK cancer centres. *British Journal of Cancer* **84**, 48–51.
- Kai J., Beavan J. & Faull C. (2011) Challenges of mediated communication, disclosure and patient autonomy in cross-cultural cancer care. *British Journal of Cancer* **105**, 918–924.
- Kennifer S.L., Alexander S.C., Pollak K.I., Jeffreys A.S., Olsen M.K., Rodriguez K.L., Arnold R.M. & Tulskey J.A. (2009) Negative emotions in cancer care: do oncologists' responses depend on severity and type of emotion? *Patient Education and Counseling* **76**, 51–56.
- Klein R. (2001) *The New Politics of the NHS*, 4th edn. Pearson, Harlow, UK.
- Kruger J. & Dunning D. (1999) Unskilled and unaware of it: how difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology* **77**, 1121–1134.
- Kruijver I.P.M., Kerkstra A., Bensing J.M. & Van De Wiel H.B.M. (2000) Nurse-patient communication in cancer care: a review of the literature. *Cancer Nursing* **23**, 20–31.
- Lancastle D., Brain K. & Phelps C. (2011) Illness representations and distress in women undergoing screening for familial ovarian cancer. *Psychology and Health* **26**, 1659–1677.
- Lenzi R., Baile W.F., Costantini A., Grassi L. & Parker P.A. (2011) Communication training in oncology: results of intensive communication workshops for Italian oncologists. *European Journal of Cancer Care* **20**, 196–203.
- Lipsett P.A., Harris I. & Downing S. (2011) Resident self-other assessor agreement: influence of assessor, competency, and performance level. *Archives of Surgery* **146**, 901–906.
- Maguire P. (1990) Can communication skills be taught? *British Journal of Hospital Medicine* **43**, 215–216.
- Maguire P. & Pitceathly C. (2002) Clinical review: key communication skills and how to acquire them. *British Medical Journal* **325**, 697–700.
- Maguire P., Booth K., Elliott C. & Jones B. (1996) Helping health professionals involved in cancer care acquire key interviewing skills – the impact of workshops. *European Journal of Cancer* **32**, 1486–1489.
- Merckaert I., Libert Y. & Razavi D. (2005) Communication skills training in cancer care: where are we and where are we going? *Current Opinion in Oncology* **17**, 319–330.
- Mitchell A.J., Hussain N., Grainger L. & Symonds P. (2011) Identification of patient-reported distress by clinical nurse specialists in routine oncology practice: a multicentre UK study. *Psycho-Oncology* **20**, 1076–1083.
- Moore P.M., Wilkinson S.M. & Rivera Mercado S. (2004) Communication skills training for health care professionals working with cancer patients, their families and/or Carers. *Cochrane Database Systematic Review* (2), CD003751.
- Moore P.M., Rivera Mercado S., Grez Artigues M. & Lawrie T.A. (2013) Communication skills training for healthcare professionals working with people who have cancer. *Cochrane Database Systematic Review* (3), CD00375.
- NICE (National Institute for Clinical Excellence) (2004) *Guidance on Cancer Services: Improving Supportive and Palliative Care for Adults with Cancer*.

- National Institute for Clinical Excellence, London, UK.
- Ong L.M.L., de Haes J.C.J.M., Hoos A.M. & Lammes F.B. (1995) Doctor-patient communication: a review of the literature. *Social Science and Medicine* **40**, 903-918.
- Ong L.M.L., Visser M.R.M., Lammes F.B. & de Haes J.C.J.M. (2000) Doctor-Patient communication and cancer patients' quality of life and satisfaction. *Patient Education and Counselling* **41**, 145-156.
- Payne S., Turner M. & O'Brien T. (2009) Exploring staff attitudes to undertaking advanced communication skills training. Research Report produced for Cancer Network. International Observatory on End of Life Care, Division of Health Research, Lancaster University. Accessed on 12/3/2013. Available at: <http://www.lancaster.ac.uk/shm/research/ioelc/programmes/documents/comms-skills-report.pdf> (last accessed 13 December 2013).
- Pollock A. (2005) *NHS plc: The Privatisation of our Health Care*. Verso, London, UK.
- Quill T.E. & Brody H. (1996) Physician recommendations and patient autonomy: Finding a balance between physician power and patient choice. *Annals of Internal Medicine* **125**, 763-769.
- Rabiee F. (2004) Focus-group interview and data analysis. *Proceedings of the Nutrition Society* **63**, 655-660.
- Rabiee F. & Bibila S. (2012). Communication in Cancer Care: Evaluating the Connected© 2-day Advanced Communication Skills Training Programme. Report produced for the NHS - NCAT, Connected Programme. Birmingham - UK, January 2012.
- Razavi D., Delvaux N., Marchal S., Bredart A., Farvacques C. & Paesmans M. (1993) The effects of a 24-hour psychological training program on attitudes, communication skills and occupational stress in oncology: a randomised study. *European Journal of Cancer* **29**, 1858-1863.
- Razavi D., Delvaux N., Marchal S., Durieux J.F., Farvacques C., Dubus L. & Hogenraad R. (2002) Does training increase the use of more emotionally laden words by nurses when talking with cancer patients? A randomised study. *British Journal of Cancer* **87**, 1-7.
- Ritchie J. & Spencer L. (1994) Qualitative data analysis for applied policy research. In: *Analyzing Qualitative Data* (eds Bryman A. & Burgess R.), pp. 172-194. Routledge, London, UK.
- Rogers A. (1986) *Teaching Adults*. Open University Press, Milton Keynes, UK.
- Schofield P.E. & Butow P.N. (2004) Towards better communication in cancer care: a framework for developing evidence-based interventions. *Patient Education and Counselling* **55**, 32-39.
- Spencer L., Ritchie J., Lewis J. & Dillon L. (2003) *Quality in Qualitative Evaluation: A Framework for Assessing Research Evidence*. Government Chief Social Researcher's Office. Cabinet Office., London, UK. Accessed on 24/07/2013. Available at: http://www.civilservice.gov.uk/wp-content/uploads/2011/09/a_quality_framework_tcm6-38740.pdf.
- Srivastava A. & Thomson S.B. (2009) Framework analysis: a qualitative methodology for applied policy research. *Journal of Administration and Governance* **4**, 72-79.
- Turner M., Payne S. & O'Brien T. (2011) Mandatory communication skills training for cancer and palliative care staff: does one size fit all? *European Journal of Oncology Nursing* **15**, 398-403.
- Wilkinson S. (1991) Factors which influence how nurses communicate with cancer patients. *Journal of Advanced Nursing* **16**, 677-688.