




Communication Challenges Among Oncologists in Mexico

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Abstract

Communication challenges related to the delivery of bad news are present in oncologists' daily practice. Hence, communication skills are essential for clinicians to handle these situations as appropriately and compassionately as possible. The aim of this study was to identify Mexican oncologists' perceptions on the most important and hardest issues to discuss with patients and their families, as well as the challenges they most commonly encounter when communicating bad news. Physicians from various oncology centers were invited to anonymously complete an electronic survey designed by our multidisciplinary oncology team. Statistical analysis was performed with the SPSS software v25; descriptive statistics were used for the analysis of the survey's answers. In total, 115 physicians were included; most were medical oncologists. Treatment objectives and prognosis were the topics most of them considered relevant to address; while end-of-life care and treatment objectives were the hardest ones to discuss. The most difficult challenges they faced when breaking bad news were being honest without taking away hope and dealing with patients' emotions. Remarkably, we detected a lack of training in delivering bad news to patients among our participants, as a minority of them had formal training in the matter. However, most desired to receive communication skills training and believed a session of 2–5 h would be sufficient. Mexican oncologists face diverse communication challenges when disclosing bad news to patients. Our findings reveal an opportunity to develop formal training programs tailored for Mexican oncologists and to ultimately improve outcomes and patient-centered care.

Keywords Bad news disclosure · Cancer · Communication · Mexico · Oncologists · Oncology

Background

In oncology, communication challenges related to the discussion of treatment options and goals of care, prognosis, existence of clinical trials, end-of-life management, and cost of care are present in daily practice, and clinicians are bound to handle them as appropriately as possible [1, 2]. Patients may

react to the disclosure of cancer diagnosis and treatment with unpredictable and difficult-to-manage emotions, which may distress clinicians and affect patient-physician relationships [3]. Moreover, communication approaches should be adapted to each patient's preferences and preconceptions, which depend on culture, religion, socioeconomic status, and educational level [4–6]. Thus, communication skills in the oncology field are essential when conveying bad news to patients and for establishing a trustful and compassionate relationship with them and their caregivers. Furthermore, successful communication facilitates treatment adherence, enhances decision-making processes, and improves outcomes [7].

Effective communication practices have a beneficial effect on the satisfaction of both patients and the health team, with a positive impact on the quality of healthcare [7]. These assertive communication competences have been traditionally considered skills innate to physicians or abilities acquired either by seeing others' practice or through their own clinical experience. However, nowadays research suggests that well-designed training courses improve physicians' communication skills and patient experience [8, 9] through the use of

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role-playing or simulation, instructional videos, and guiding frameworks for the delivery of bad or complicated news, like SPIKES [10] and SHARE [11].

Due to the need for effective communication in the cancer setting, different oncology educational programs in western countries have included communication skills training (CST) as part of their curricula [2, 12, 13]. Likewise, the Global Curriculum in Medical Oncology training endorsed by ESMO/ASCO has a dedicated section regarding communication skills [14]. Similar efforts have been starting to rise in Latin America to include CST in both medical training and clinical practice in diverse medical fields [15, 16]. However, there is still scarce information about the specific communication challenges that Latin American oncologists face on a daily basis in their profession. It is imperative to narrow this gap in order to improve communication between the oncology team, patients, and their families.

The aim of the present study is to identify Mexican oncologists' perceptions on the most important and most difficult issues to discuss with patients and their families, as well as the challenges they most commonly encounter when communicating bad news to their patients.

Methods

A cross-sectional study was performed through the use of a 14-question survey designed by our multidisciplinary oncology team. The first four questions were focused on general participant characteristics (age, gender, specialty, education level). The rest were included mainly based on questions from a survey that assessed attitudes and practices regarding breaking bad news [17], as well as through the selection of three questions based on the recommended steps of breaking bad news regarding the thoughtful transmission of clear messages and the fulfillment of information needs [18]. Two final questions were added by our team to explore participants' interest in receiving CST and its format. The survey assessed the most relevant and most difficult topics to discuss with oncology patients while delivering bad news, as well as the most frequent challenges physicians faced during the information exchange. In addition, it evaluated participants' communication skills and, in a final section, assessed their interest in being trained on disclosing bad news and the amount of time they considered necessary for such training.

Physicians from various public and private oncology centers in Mexico were reached out through three preexisting instant messaging groups frequently used as a means of communication of different topics among oncologists from different cities in Mexico. An instant message was sent to each of the groups with an invitation for members to voluntarily and anonymously complete our questionnaire. Consent to participate was obtained from all individuals included in the study

through an introductory paragraph that stated the aim of the survey and asked about their desire to act as participants in this research.

To assess their impressions on the most relevant topics to address when communicating bad news to oncology patients and their relatives, participants selected one or more of the following options: treatment objectives, treatment selection, prognosis, disease recurrence/progression, and end-of-life care. In a subsequent question, physicians ordered the same options according to their perception of the level of difficulty to address them. Physicians also ordered, from most difficult to least difficult, the following communication challenges they faced when disclosing bad news to patients: being honest while not taking away hope, dealing with patients' emotions, involving patients' friends and/or families in discussions, involving patients and/or their families in decision-making, and spending the right amount of time with the patient during each consultation [2].

To evaluate their communication skills, physicians answered always, often, sometimes, rarely, or never for the following questions: Do you usually have a clear message of what you want to transmit to your patients during your consultation? How often do you ask your patients what information they need? When you finish your explanations, do you check if your patient understood your message? They also responded yes, no, or not sure to a question inquiring if they considered images to be useful during their explanations to patients.

Additional questions asked about physicians' previous training in delivering bad news, their interest in receiving training in communicating bad news, and the amount of time they considered necessary for such training.

During data analysis, to evaluate if demographic characteristics had an impact on their answers, participants were divided into two age groups (≤ 40 or > 40 years old), according to gender (female or male) and depending on their academic grade (specialist or fellow).

Data was anonymously collected and electronically processed. Statistical analysis was performed with the statistical software SPSS version 25 (SPSS Inc., Chicago, Illinois). Descriptive statistics were used for the analysis of the survey's answers. Frequencies and percentages were used for categorical data; and medians (interquartile range), for quantitative data. Chi-square and Mann-Whitney's U tests were used to compare groups for categorical and continuous variables, respectively, and to evaluate their association. A two-sided p value < 0.05 was considered significant for each of these tests.

Results

A total of 115/314 (37%) physicians voluntarily participated in this survey. Sixty-five (57%) were men. Median age was

40 years (range 27–67 years); and men were older than women (mean age of 65 vs. 43 years). Most (82%) were medical oncologists. Fifty-seven (50%) participants were senior oncologists (> 40 years old), 45 (39%) were young oncologists (\leq 40 years old), and 13 (11%) were oncology fellows. Demographic characteristics are listed in Table 1.

Most oncologists considered treatment objectives (98%) and prognosis (94%) as relevant issues to discuss with patients and their relatives. Recurrence (77%) and end-of-life care (62%) were relevant for fewer physicians.

As for the most difficult issue to address, more physicians considered it was either end-of-life care (29%) or treatment objectives (23%) (Table 2). When asked about the most difficult challenge they faced when conveying bad news, participants more commonly indicated it was being honest without taking away hope (43%) or dealing with patients' emotions (22%) (Table 3). In addition, when evaluating age groups, participants \leq 40 years considered that involving patients' friends and/or families in the discussion was a difficult challenge to address ($p = 0.007$).

Clinicians' application of communication skills in their clinical practice was also evaluated. A vast majority of them (97%) always or often had a clear message about what they wanted to transmit to their patients during their consultation; 78% always or often asked their patients what topics they needed them to cover in more detail; and 90% always or often corroborated if their patients understood the message after having finished their explanation (Table 4). In this exploratory survey, men more often responded they had a clear message of what they wanted to convey when compared to women ($p = 0.021$). Additionally, 67% of the participants found it useful to employ images during their explanations to patients.

Table 1 Participants' demographic characteristics

Characteristic	<i>N</i> = 115 (100%)
Gender	
Male	65 (57)
Female	50 (43)
Median age in years (range)	40 (27–67)
Median age by sex in years (range)	
Male	46 (28–67)
Female	39 (27–62)
Academic grade	
Specialist	102 (89)
Fellow	13 (11)
Specialty	
Medical oncologist	94 (82)
Surgical oncologist	7 (6)
Radio-oncologist	5 (4)
Others	9 (8)

Table 2 Relevant and most difficult topics to discuss with patients

Topic	Relevant to discuss [†] <i>N</i> = 115 (100%)	Most difficult to discuss <i>N</i> = 115 (100%)
Treatment objectives	113 (98)	27 (23)
Prognosis	108 (94)	19 (16)
Treatment selection	96 (83)	17 (15)
Disease recurrence/- progression	88 (77)	20 (17)
End-of-life care	71 (62)	33 (29)

[†]Percentages do not add up to 100% because participants could choose more than one answer

Finally, only 29% of participants had previous training in delivering bad news, and most (93%) wanted to receive such training. There were no significant differences between having and not having previous CST and academic grade, specialty, age, or gender. However, clinicians \leq 40 years were more interested in receiving training than those > 40 years (98% vs. 88%, $p = 0.026$). Regarding the number of hours that participants considered enough to receive CST, most (52%) stated that 2–5 h of training was an adequate amount of time (Table 4).

Discussion

To our knowledge, this is the first exploratory study focused on the communication barriers faced by Mexican physicians when disclosing bad news to oncology patients in their daily practice. Participants considered that the most relevant issues to discuss with patients were treatment objectives and prognosis, both of which are directly part of an oncologist's usual practice. Similarly, a previous study also recognized the importance of providing information about breast cancer and its

Table 3 Physicians' main communication challenges when delivering bad news

Challenge	Most difficult to address <i>N</i> = 115 (100%)	Least difficult to address <i>N</i> = 115 (100%)
Being honest while not taking away hope	50 (43)	14 (12)
Dealing with patients' emotions	25 (22)	11 (10)
Time availability	18 (16)	65 (56)
Involving patients' friends and/or families in the discussion	13 (11)	18 (16)
Involving patients' friends and/or families in decision-making	9 (8)	7 (6)

Table 4 Frequency of communication skills application in daily clinical practice and interest in receiving training in breaking bad news

Question/answer	N = 115 (100%)
Do you usually have a clear message of what you want to transmit to your patients during your consultation?	
Always	55 (48)
Often	57 (49)
Sometimes/rarely/never	3 (3)
How often do you ask your patients about what information they need to now?	
Always	47 (41)
Often	43 (37)
Sometimes/rarely/never	25 (22)
When you have finished your explanation, do you check if your patients understood your message?	
Always	70 (61)
Often	33 (29)
Sometimes/rarely/never	12 (10)
Do you consider the use of images a useful tool to explain these topics to your patients?	
Yes	77 (67)
No/not sure	38 (33)
Have you received any training in disclosing bad news?	
Yes	33 (29)
No	82 (71)
Would you like to receive training in breaking bad news?	
Yes	107 (93)
No	8 (7)
How many hours would you consider appropriate for receiving this training?	
2 h	34 (30)
5 h	25 (22)
8 h	15 (13)
10 h	12 (10)
> 10 h	23 (20)
I am not interested in receiving such training	6 (5)

treatment goals, options, and side effects [19]. However, it has been reported that oncologists miss several opportunities for addressing these issues more thoroughly, probably due to patients' preferences and physicians' communication behaviors [20].

In contrast, addressing recurrence and end-of-life care were relevant for fewer of our participants. This could not necessarily mean that physicians regard these topics as less important ones, but that they usually address first the other options such as treatment objectives and prognosis, leaving recurrence and end-of-life care for follow-up visits. Nonetheless, it is still necessary to thoroughly cover these topics since most cancer patients usually prefer to receive as much information as possible, regardless of it being related to good or bad news [21].

In this sample, participants considered that talking about end-of-life care was the hardest topic to discuss with patients. Addressing this subject might be difficult for oncologists since palliative and end-of-life care is a service that they do not provide directly. It is relevant to note that our participants' opinion on the difficulty of addressing end-of-life issues was divided: 29% considered it was the hardest topic to discuss, while 32% considered it was the easiest issue to address, a phenomenon that is probably related to each participant's experiences. No significant sociodemographic difference was found between the groups that differed in their opinion on this matter.

Physicians also stated that the hardest part of conveying bad news was being honest while not taking away patients' hope, as well as dealing with patients' emotions, similar to what has been reported by others [10, 22]. Moreover, even if physicians attempt to address death and dying, patients are often unwilling to talk or think about these topics [22]. In comparison, when analyzing age groups, younger oncologists considered involving patients' friends and/or families in decision-making processes to be especially challenging. A study involving mainly young medical oncologists also reported that they encounter several difficulties related to family members' and friends' involvement in cancer care [19].

Most physicians in our study had a clear message of what they wanted to transmit to their patients. However, a lower percentage inquired their patients what topics they needed them to cover in more detail. Nonetheless, most of our participants, independently of their age or gender, reported that they always or often asked their patients about their information needs and checked if they understood the message after providing them an explanation. In contrast, only 38% of Mexican internal medicine residents in another study asked patients about their doubts and desire for more information [23]. These differences may be due to regional cultural norms that influence oncologists' attitudes toward information disclosure and, indirectly, their self-reported behaviors [24]. In addition, perceived institutional professional norms and the degree of training in breaking bad news also impact on medical oncologists' practices [24].

In our study, we also observed that female physicians less frequently had a clear message of what they wanted to transmit to their patients. This finding could probably be related with clinicians' ages, given that female participants were in average 10 years younger than males. Nevertheless, literature shows that female physicians are more likely than males to adopt a partnership-building style and spend an average of 2.24 min longer with their patients per consultation (95% CI 0.62–3.86) and place a greater value on patient-physician communication [25, 26].

It has been demonstrated that CST is a fundamental tool for breaking bad news and has been associated to higher patient satisfaction, better patient adherence to treatment, improved

health outcomes, and better patient-physician relationships [27]. Remarkably, we detected a lack of training in delivering bad news to patients among our participants, as only 29% of them had a formal training in the matter, which is similar to what has been reported by other authors [23, 24, 28]. This low rate could be explained by the limited availability, particularly in Latin America, of CST as part of the curricula of oncology residencies [16]. The National Cancer Institute has adapted the Baile-Buckman protocol SPIKES, a six-step protocol for aiding clinicians in disclosing unfavorable information and breaking bad news to cancer patients [10, 29]. However, it is not part of the formal academic curriculum of oncology residents [29]. Therefore, as it has been previously recommended by other specialists, more efforts are still needed to improve Latin American clinicians' training in communicating bad news in order to enhance communication and outcomes in cancer care [2, 23].

The vast majority of our participants desired to receive CST, and we detected even more interest among younger participants, probably due to their limited experience in disclosing bad news. Their eagerness should be exploited given that younger clinicians may be more inexperienced and might lack emotional competence when delivering adverse or complicated messages [30]. In contrast, Karger et al. suggested that physicians with more professional experience might have a higher need of CST for dealing with difficult encounters and emotions [9].

Finally, while many participants wanted to receive CST, a high proportion of them considered that only 2–5 h of training would be sufficient. This is consistent with the finding that physicians feel more comfortable with modular training courses with short half-day teaching sessions [9]. Nonetheless, the optimal duration of CST has been previously evaluated in other cancer centers and institutions, and it has been reported that CST programs that last < 24 h have limited efficacy as compared to those that last \geq 24 h and include posterior regular training sessions [31, 32]. Longer programs may be more effective because they produce significantly more changes in physicians' communication skills, including increased awareness of specific communication techniques and of patients' needs, greater engagement in discussions with patients, reduced negative affect in the interviews, and more behaviors with a patient-centered style of interviewing [33, 34].

Study Limitations

Our study presents some limitations. First, less than 50% of the physicians who were invited to participate accepted to do so. This could introduce a participation bias in which participant oncologists were more interested in communication skills and practices than nonrespondents, which could influence survey answers and overestimate the interest in CST. Second, it

was not asked about physicians' years of clinical experience, the number of times they gave bad news per week, if they worked in a public or private institution, or the geographical area where they worked in Mexico. Also, the researchers did not ask for information about training location of those physicians who had received previous CST. Therefore, we ignore the duration of their training and if it was part of their oncology academic program, an institutional proposal, a medical school training or workshop, or a personal initiative. Moreover, our survey included multiple-choice questions that limited participants' possible answers. Future surveys could use open-ended questions to further explore physicians' opinions on relevant topics and other communication challenges they face in order to see if they have additional concerns besides the ones found in this study. It would also be interesting to assess how often physicians use visual aids to explain bad news in their daily practice and the most common places where they deliver bad news. Finally, future studies could explore how often oncologists involve patients' families in the process, as well as the frequency in which family members ask them to share bad news with them first and then with the patients, which could give rise to ethical and legal issues if such request is not in accordance with the patients' needs and preferences.

Clinical Implications

Our study is the first to shed some light onto Mexican oncologists' communication challenges when disclosing bad news and their willingness to receive formal training on communication skills. The knowledge provided by our study promotes the training of physicians with directed communication strategies when conveying bad news. In this way, our results encourage the use of training tools that will enhance communication practices, which have a paramount impact on high-quality patient-centered care in the oncology field.

Conclusions

Mexican oncologists face diverse communication challenges when delivering bad news to patients in their daily practice. Treatment objectives and prognosis are the topics that most of them consider relevant to address, while end-of-life care and treatment objectives are the hardest ones to discuss. In addition, the most difficult challenges faced by this group of oncologists when breaking bad news are being honest without taking away hope and dealing with patients' emotions. Finally, most of these clinicians desire to receive CST, which represents an area of opportunity to develop formal training programs in Mexico and ultimately, improve patient-centered care.

Author Contributions Conceptualization of this study was headed by Alejandra Platas, Cynthia Villarreal-Garza, and Alejandro Mohar; Methodology was headed by Alejandra Platas, Cynthia Villarreal-Garza, and Alejandro Mohar; Data collection was headed by Ariel Jasqui-Bucay and Fernanda Rivera; Formal analysis was headed by Sylvia de la Rosa-Pacheco; Writing “original draft preparation” was headed by Marlid Cruz-Ramos, Fernanda Mesa-Chavez, Alejandro Mohar, and Cynthia Villarreal-Garza; Writing “review and editing” was headed by Marlid Cruz-Ramos, Fernanda Mesa-Chavez, and Cynthia Villarreal-Garza; and Supervision was headed by Cynthia Villarreal-Garza.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest to disclose.

Ethical Approval This study was performed through the application of an anonymous electronic survey, and the invitation for physicians to answer the questionnaire was made specifying and emphasizing that their participation was voluntary and their answers were completely anonymous, with no possibility for researchers to track either who answered the survey or which were each participant's answers. Due to the anonymous and untraceable nature of the questionnaire and no more than minimal risk to participants related to the study, an ethics committee approval was not required.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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