

Communication Skills Training for Oncology Professionals

David W. Kissane, Carma L. Bylund, Smitta C. Banerjee, Philip A. Bialer, Tomer T. Levin, Erin K. Maloney, and Thomas A. D'Agostino

All authors: Memorial Sloan-Kettering Cancer Center, New York, NY.

Submitted September 16, 2011; accepted January 11, 2012; published online ahead of print at www.jco.org on March 12, 2012.

Supported by National Cancer Institute Grant No. R25 CA134252 (D.W.K.).

Authors' disclosures of potential conflicts of interest and author contributions are found at the end of this article.

Corresponding author: David W. Kissane, MD, Memorial Sloan-Kettering Cancer Center, 641 Lexington Ave, 7th Floor, New York, NY 10022; e-mail: kissaned@mskcc.org.

© 2012 by American Society of Clinical Oncology

0732-183X/12/3011-1242/\$20.00

DOI: 10.1200/JCO.2011.39.6184

A B S T R A C T

Purpose

To provide a state-of-the-art review of communication skills training (CST) that will guide the establishment of a universal curriculum for fellows of all cancer specialties undertaking training as oncology professionals today.

Methods

Extensive literature review including meta-analyses of trials, conceptual models, techniques, and potential curricula provides evidence for the development of an appropriate curriculum and CST approach. Examples from the Memorial Sloan-Kettering Cancer Center CST program are incorporated.

Results

A core curriculum embraces CST modules in breaking bad news and discussing unanticipated adverse events, discussing prognosis, reaching a shared treatment decision, responding to difficult emotions, coping with survivorship, running a family meeting, and transitioning to palliative care and end of life. Achievable outcomes are growth in clinician's self-efficacy, uptake of new communication strategies and skills, and transfer of these strategies and skills into the clinic. Outcomes impacting patient satisfaction, improved adaptation, and enhanced quality of life are still lacking.

Conclusion

Future communication challenges include genetic risk communication, concepts like watchful waiting, cumulative radiation risk, late effects of treatment, discussing Internet information and unproven therapies, phase I trial enrollment, and working as a multidisciplinary team. Patient benefits, such as increased treatment adherence and enhanced adaptation, need to be demonstrated from CST.

J Clin Oncol 30:1242-1247. © 2012 by American Society of Clinical Oncology

INTRODUCTION

Effective communication is central to the clinician-patient encounter. When the patient's needs and concerns are well understood through a biopsychosocial formulation, then a comprehensive care plan can be mutually agreed on. Communication skills training (CST) has become one vehicle to build skills that optimally advance the clinical agenda, alongside promoting professionalism and excellence of care. Good communication skills have been linked to higher patient satisfaction, greater patient adherence to treatment, better patient health outcomes, fewer physician malpractice claims, reduced patient anxiety, increased recall, and improved understanding.¹

Patients with cancer report unmet communication needs for information about the extent of disease, prognosis, and treatment options, intent, and adverse effects.² This is consistent with earlier studies identifying communication problems in

84% to 94% of clinical encounters.³⁻⁵ When the clinician is responsive to patients' needs, their anxiety levels have been significantly reduced.⁶ Further, an association has been found between psychosocial factors and survival after controlling for disease factors,⁷ with the impact of a hopeless/helpless psychological style and adherence to anticancer treatments prominent as mediating factors.^{8,9} Patient-centered communication stands out as a crucial clinical skill to optimize outcomes.

In this article, we review the current state of the art of CST for oncology professionals, including theoretical models that inform CST program design, curriculum, efficacy of CST, facilitation principles, assessment methods, outcomes, and future challenges. We propose the establishment of a universal CST curriculum for fellows of all cancer specialties that builds their professionalism and sustains effective clinician-patient communication throughout their careers.

THEORETICAL FOUNDATIONS FOR CST

Recent advances in CST have emphasized the need for theoretically sound training programs, noting that the theoretical basis for such training has historically been weak.¹⁰⁻¹² A theoretical framework helps explain why training components improve outcomes.¹³

Literature from provider-patient communication studies, communication theory, and educational psychology offers a theoretical basis.¹⁰ Goals, plans, and action (GPA) theories,¹⁴ sociolinguistic theory,¹⁵ and Leventhal's common-sense model (CSM)¹⁶ provide a solid foundation for CST. Here we review these three theories.

GPA Theories

When communicating, people rely on goals and plans to guide what they say.¹⁴ Goals are defined as future states of affairs that an individual is committed to achieving or maintaining. Plans are the cognitive representations of behaviors that empower goal attainment. More concretely, actions are the behaviors that are enacted to realize the goal.¹⁷ Thus, goals are connected to actions through plans, an approach with obvious utility for CST, wherein a series of steps or strategies accomplish the goal of the communication. Moreover, to attain any single goal, multiple plans and actions may be needed. For instance, to help a patient fully integrate understanding of bad news (goal), a strategy of respond empathically to emotion (plan) may be accomplished through acknowledging, validating, or normalizing the patient's emotional response (actions).¹⁰ Similarly, breaking bad news (goal) could be attained using the strategy of providing information in a way that it will be understood (plan), which may be accomplished through previewing what will be shared, summarizing the information, and later checking what the patient has understood (actions).

Sociolinguistic Theory

Sociolinguistic theory describes the process of communication from the following two orientations: the position-centered approach and the person-centered approach.¹⁵ The position-centered approach relies on a restricted focus on the diagnosis and treatment as a predicament that the patient is expected to negotiate, perhaps solely following social norms for dealing with this experience. In contrast, the person-centered approach adapts the communication to better meet the needs, feelings, and reactions of the recipient.¹⁵ This tailoring of the communication in a manner that is sensitively responsive to the patient aims to improve understanding and integration of the content perceived as so vital to outcome.

Leventhal's CSM

Leventhal has proposed that illness is primarily understood through common sense, wherein each patient listens to the physician's explanation, questions and deepens his or her understanding, and thus gradually develops a comprehensive concept of what the illness is.¹⁶ The process becomes self-regulating, with reciprocal cross checking and updating to extend this dynamic understanding until a shared position is truly reached.¹⁸ This CSM focuses on the following two dimensions that describe the relationship between care seeking and self-management of chronic illness: patients' representations of illnesses and treatments, and how patients appraise somatic changes (ie, symptoms and function).¹⁹⁻²¹ In other words, patients hold a series of assumptions or health beliefs (which may be medically sound or

unsubstantiated) as their explanations of illness, including culturally determined ideas.²² In addition, patients develop representations of treatment, perceived causal routes of action, expectations regarding efficacy, time frames for response, and consequences (adverse effects). Their understanding is continually modified as new information is presented (from health care practitioners, friends, family, and mass media) and adjusted to.²³

These representations of the CSM are governed by the following five key domains: the self-identity of the person as healthy or ill; potential causes of illness, whether understood medically or based on folk or supernatural beliefs; the timeline for achieving diagnosis and treatment; consequences of both the illness and its treatment; and whether control or cure can be achieved.^{24,25} Action plans, such as specific times and places for implementing treatment, link both the perception of illness and its treatment to performance. There are multiple levels at which such mental representations of illness operate and guide patients' preferences and adherence to treatment over time.²⁶ The practitioner's ability to check understanding of each patient's explanatory model of illness and help move this toward the clinician's medical model is a core component of effective clinician-patient communication.

Thus, GPA theory, patient-centered linguistics, and the CSM of illness representation become integrated in CST to optimize patient outcomes. Sometimes, the clinician is focused on creating goals and plans and overseeing resultant actions; at other times, the communication challenge lies in recognizing dissonance between the patient's explanation and medicine's explanation for the illness or its treatment and striving toward improved consensus. A central orientation to the needs of each person is fundamental to successfully integrate these theories into effective communication.

STATE OF THE ART OF CST

The effects of CST interventions for health care professionals have been compiled and analyzed in several systematic reviews across recent decades.^{10,27-29} These reviews have consistently concluded that CST leads to better communication behaviors among clinicians.^{27,29} A recent meta-analysis of 13 studies reported a moderate effect size of 0.54 (Cohen's *d*) for the impact of CST on communication behaviors of oncology clinicians.²⁹ Although limited by the exclusion of CST studies on recruitment of patients onto clinical trials, shared decision making, and genetic counseling, this effect size is quite noteworthy.

Importantly, these reviews also conclude that improved clinician behaviors have not yet translated into better patient outcomes.^{10,28,29} Evidence for the latter is crucial for determining the value of CST training because, as observed by Cegala and Lenzmeier Broz,¹⁰ "Although it is important to establish that skills training results in significant improvement in providers' communication, the ultimate goal of such training is to enhance the quality of health care."

In addition to the lack of evidence for improved patient outcomes, several other limitations have been noted consistently across reviews. First, most noted the absence of focus and consistency across studies, including agreement about what is considered a communication skill¹⁰ and heterogeneity of content, design, and outcome measures for training programs.²⁸ Another limitation is the infrequent investigation of the dose of CST (eg, use of booster or consolidation sessions) to sustain long-term beneficial effects.^{30,31}

Future CST research should seek to address these limitations and identify the specific characteristics that make a program more or less effective. Duration of training, nature of outcome evaluations, and profession of participants are potential moderators of effectiveness.²⁹ CST courses less than 24 hours in length were less effective than those greater than 24 hours; in general, nurses have enjoyed the longer courses with stronger effects.^{29,30} Finally, whether CST used simulated or real patients for outcome assessment has produced no clear conclusion about the long-term maintenance of skills in the clinic.

AN OPTIMAL MODEL FOR CST FOR ONCOLOGY FELLOWS

Given the work from the last three decades,³²⁻³⁴ we can synthesize the key ingredients that evidence supports for CST today and argue that this should now be the standard for all oncology training programs. Art, science, and practical wisdom need to be combined in a program that is learner centered, flexible, engaging, and instructive.³⁵ This does not result from a witty lecture, but needs an experiential process of role-play to practice skill development.³⁶ Video recording of role-play in a safe, simulated setting with an actor³⁷ allows for reflection, immediate playback and feedback, and rerunning of the exercise until improvement is witnessed and the responsible contributory components are appreciated. Such role-play work with small groups of three to four learners is facilitated by an experienced clinician or cofacilitator pair.

At Memorial Sloan-Kettering Cancer Center, we have standardized what is taught and how this is facilitated through a modular approach, wherein the key components of the clinical consultation are broken up into manageable parts called modules, as illustrated in the curriculum that follows. Each module has an overarching goal, which is achieved through use of a set of strategies that are laid out in a clinically meaningful sequence of steps. Strategies, in turn, are achieved through the use of a series of communication skills, defined as discrete verbal utterances, which are complemented by nonverbal behaviors, termed process tasks, which create an appropriate environment for effective communication. Through reflection, the clinician constantly appraises any cues offered by the patient for information or support, while also monitoring any barriers that could also appear in either party and that would impede the communication. Figure 1 shows the interrelationship of these core communication concepts.

In the future, the field will not be able to depend on organizations, such as the American Society of Clinical Oncology, or National

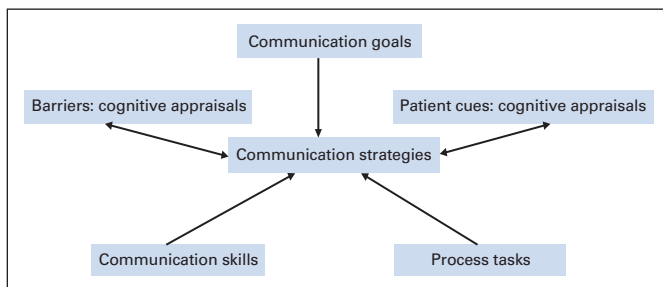


Fig 1. Core components of what is taught in communication skills training modules. The goal is achieved through the execution of a series of sequenced strategies, which in turn are accomplished via use of skills and process tasks. Cues from the patient initiate cognitive appraisals in the clinician, whereas barriers that block open communication can arise in either party.

Table 1. Communication Skills Training Curriculum for Oncology

Basic Core Curriculum for Oncology	Advanced Curriculum for Oncology
1. Breaking bad news	1. Clinical trial enrollment
2. Discuss prognosis and risk	2. Cancer genetics
3. Shared decision making	3. Survivorship
4. Responding to emotions	4. Treatment adherence
5. Deal with recurrence	5. Discuss Internet and unproven therapies
6. Transition to palliative care	6. Culturally determined beliefs
7. Run a family meeting	7. Working as multidisciplinary team
8. Discuss death and dying	8. Discuss infertility and sexuality

Cancer Institute–funded research grants, such as the R25 grant supporting our work at Memorial Sloan-Kettering Cancer Center or prior R25 grants like Oncotalk,³⁴ to sustain these endeavors. The standards used to accredit training programs by the Accreditation Council on Graduate Medical Education include communication and professionalism as core requirements, and we contend that this accreditation process will appreciate the crucial contribution of CST to specialist education, as it has for medical school education, and drive the universal adoption of a core curriculum for accredited programs in the future.

A CORE CURRICULUM FOR CST IN ONCOLOGY

Whereas medical schools commonly teach generic communication skills, such as nonverbal behaviors that support the dialogue and skills in questioning, listening, appraising cues, and avoiding barriers to effective communication, specialty training programs move on to applied communication skills, specific to the illness complexity and management challenges of the discipline (Table 1). This developmental agenda takes heed of the hidden curriculum, wherein poor modeling from respected senior clinicians may undermine what was learnt in earlier years of medical school.³⁸

A basic core curriculum for oncology covers how to break bad news (diagnosis), discuss unanticipated adverse events (operating room outcomes), discuss prognosis at each illness phase, develop shared decision making for anticancer treatments, respond to difficult emotions, deal with recurrence, transition patients with progressively advanced cancer to palliative care, run a family meeting, and discuss death and dying, including advanced care planning and allow natural death (rather than do not resuscitate) directives.³⁹ Training directors running Accreditation Council on Graduate Medical Education–accredited programs, together with CST researchers, have reached consensus that this core curriculum is the most compelling at this stage of CST development.

In the future, new modules will inevitably be developed to meet the needs of specific fellowship programs, exemplified by options like clinical trial enrollment, discussion of genetic risks, preparation for survivorship, promotion of treatment adherence and optimal pain control, responding to culturally specific health beliefs, infertility and sexuality, working as a multidisciplinary team, discussing the danger of radiation, rehabilitative and salvage surgeries, the role of complementary and unproven therapies, beneficial use of Internet information, watchful waiting management, and preventive cancer screening.

FACILITATING CST

Each small CST role-play group should optimally have three learners engaged in 90 minutes of role-play together, giving each learner 30 minutes to practice skills and receive feedback. A trained facilitator provides learner-centered guidance through tasks that include eliciting learning goals, inviting feedback from the group, and ensuring a balance of positive and constructive feedback.⁴⁰

Rather than only relying on a small team of behavioral scientists to facilitate CST, we recommend a larger group of facilitators from multiple disciplines. We do this using a train-the-trainer approach that invites facilitator trainees to first participate in CST as learners, becoming familiar with the curriculum and experience of training.

Training a larger group of facilitators is important for several reasons. First, involving facilitators from the discipline that participants are from provides good modeling and attends to the hidden curriculum.⁴¹ For example, a surgery fellow facilitated by a senior surgeon understands that this is important to the surgical department. Second, involving facilitators with the content knowledge of each learner's discipline ensures accurate role-play scenarios. Third, this approach increases overall investment from the various disciplines. When senior clinicians facilitate, they value the program and are more likely to encourage participation.

An even better approach, and what we consider best practice, is to have each group cofacilitated, with one facilitator from the learner's discipline and another facilitator with more training in psychosocial aspects of patient care (ie, psychiatrist or psychologist). Feasibility here may be limited by availability.

A central concern is how to most effectively maintain fidelity of facilitation across small groups using multiple facilitators. The consensus here is as follows.⁴²

First, guidelines and standards should be developed. A uniform set of standardized tasks for facilitation is based on adult learning theory and guidelines from previously established programs.⁴⁰

Second, facilitators must be trained. Train facilitators through a module focused on facilitation, with role-play practice in which trainees take on the role of the facilitator in a mock training session.⁴⁰

Third, facilitators should be assessed and feedback should be provided to them. The adherence to facilitation guidelines can be assessed by the Facilitator Assessment Coding System, which is applied to audio recordings of trainings.⁴³ Facilitators can then be given written feedback longitudinally. When clinicians only facilitate CST annually, maintenance of facilitator skills proves surprisingly elusive.

Fourth, sessions should be assessed. In research protocols, we use two facilitators (discipline specialist and psychosocial) and then audio record and assess adherence to guidelines by the cofacilitator pair. This allows for a more experienced facilitator to be paired with one less experienced, while still accomplishing the goals of the session. We have found acceptable adherence across groups doing this.

ASSESSMENT OF CST

Adequate evaluation of learning is a crucial component within any educational training program. Kirkpatrick's Triangle,^{44,45} a widely used assessment model, calls for four levels of evaluating educational trainings to assess their impact (Fig 2). The first level focuses on reactions to CST, offering an opportunity for trainees to voice their

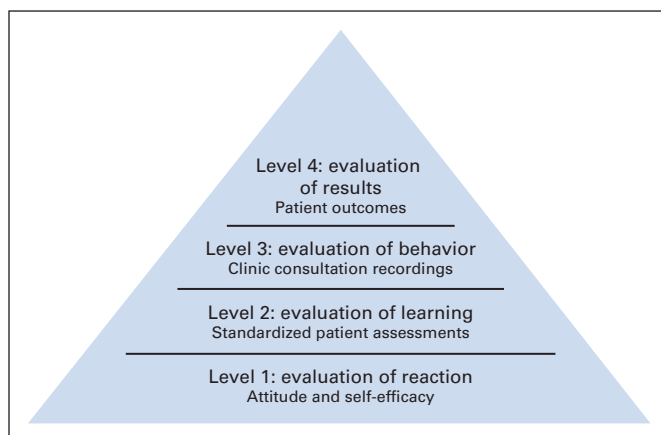


Fig 2. Kirkpatrick's Triangle representing levels of assessment in communication skills training.

opinions, self-efficacy, and level of satisfaction with the training. The second level evaluates acquired knowledge and skills through standardized patient assessments, in vitro, in the CST lab. The third level centers on assessing actual change in behavior that is transferred into the clinic, the in vivo setting, with actual patients in the workplace. The fourth and highest level assesses the overarching goal or large-scale impact of the training program. Within health care communication training research, this is frequently evaluated through measurement of patient and health care outcomes.

The assessment method used within our Memorial Sloan-Kettering Training Program is similar to Kirkpatrick's Triangle. In the first level of evaluation, trainees are asked to complete anonymous course evaluations rating their satisfaction with each module. Space is provided to write in suggestions and additional comments. In the second level, standardized patient assessments are conducted before and after training to measure immediate uptake of skills. In the third level, trainee behavior is assessed by rating the use of communication skills within video-recorded consultations conducted in actual clinics with real patients. Recordings are again collected before and after training for each trainee. The Comskil Coding System, which was developed to assess the use of communication skills and strategies included within our curriculum,⁴⁰ is used to code each consultation and standardized patient assessment. We are currently in the process of gathering initial data to evaluate the fourth level of Kirkpatrick's model, collecting patients' ratings of how well their doctor communicates, understands their needs, and responds accordingly.

OUTCOMES OF CST

As an illustration of the potential outcomes of CST at comprehensive cancer centers, over the last 5 years, Memorial Sloan-Kettering Cancer Center has trained 657 clinicians, comprising 183 attending physicians and surgeons, 410 fellows and residents, and 64 nurses. Approximately 94% of trainees have reported undertaking a critical evaluation of their communication skills, whereas 92% believed that their patient care would be enhanced. These clinicians reported significant improvement in their self-efficacy in communicating effectively (change from 4.08 to 4.82 on a 5-point scale; $P < .01$ on paired t tests). Standardized

patient assessments before and after training have demonstrated significant gains in skill uptake such as agenda setting, checking patient understanding, and information organization, such as previewing and summarizing. These skills transfer into the clinic.⁴⁶ Uptake of new skills is greater in clinicians who complete more modules, a clear dose effect that is consistent with the extant literature.

CONCLUSION

Meta-analyses confirm that CST leads to the uptake of new skills, which can be taken into the clinic to enhance communication in cancer care. Patient outcomes such as improved satisfaction with the communication, growth in knowledge, improved treatment adher-

ence, and better quality of life still need to be demonstrated in CST studies. Nevertheless, the state of the science has matured so much that CST programs ought now to be part of oncology fellowship training offered by comprehensive cancer centers.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author(s) indicated no potential conflicts of interest.

AUTHOR CONTRIBUTIONS

Manuscript writing: All authors

Final approval of manuscript: All authors

REFERENCES

- Epstein R, Street RL Jr: Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering. Bethesda, MD, National Cancer Institute, NIH publication 07-6225, 2007
- Hack TF, Degner LF, Parker PA, et al: The communication goals and needs of cancer patients: A review. *Psychooncology* 14:831-845, 2005
- Lerman C, Daly M, Walsh WP, et al: Communication between patients with breast cancer and health care providers: Determinants and implications. *Cancer* 72:2612-2620, 1993
- Fallowfield L, Lipkin M, Hall A: Teaching senior oncologists communication skills: Results from phase I of a comprehensive longitudinal program in the United Kingdom. *J Clin Oncol* 16:1961-1968, 1998
- Foot G, Sanson-Fischer R: Measuring the unmet needs of people living with cancer. *Cancer Forum* 19:131-135, 1995
- Butow P, Devine R, Boyer M, et al: Cancer consultation preparation package: Changing patients but not physicians is not enough. *J Clin Oncol* 22:4401-4409, 2004
- Butow PN, Coates AS, Dunn SM: Psychosocial predictors of survival in metastatic melanoma. *J Clin Oncol* 17:2256-2263, 1999
- DiMatteo MR, Giordano PJ, Lepper HS, et al: Patient adherence and medical treatment outcomes: A meta-analysis. *Med Care* 40:794-811, 2002
- Watson M, Homewood J, Haviland J, et al: Influence of psychological response on breast cancer survival: 10-Year follow-up of a population-based cohort. *Eur J Cancer* 41:1710-1714, 2005
- Cegala DJ, Lenzmeier Broz S: Physician communication skills training: A review of the theoretical backgrounds, objectives and skills. *Med Educ* 36:1004-1016, 2002
- Brown RF, Bylund CL: Communication skills training: Describing a new conceptual model. *Acad Med* 83:37-44, 2008
- Hulsman RL: Shifting goals in medical communication: Determinants of goal detection and response formation. *Patient Educ Couns* 74:302-308, 2009
- Coyne JC, Racioppo MW: Never the twain shall meet? Closing the gap between coping research and clinical intervention research. *Am Psychol* 55:655-664, 2000
- Berger CR: Planning Strategic Interaction: Attaining Goals Through Communicative Action. Mahwah, NJ, Lawrence Erlbaum, 1997
- Miller K: Communication Theories: Perspectives, Processes, and Contexts. Boston, MA, McGraw-Hill, 2002
- Donovan HS, Ward S: A representational approach to patient education. *J Nurs Scholarsh* 33:211-216, 2001
- Wilson SR, Morgan WM: Goals-Plans-Action Theories: Theories of Goals, Plans and Planning Processes in Families. Thousand Oaks, CA, Sage, 2006
- McAndrew LM, Musumeci-Szabó TJ, Mora PA, et al: Using the common sense model to design interventions for the prevention and management of chronic illness threats: From description to process. *Br J Health Psychol* 13:195-204, 2008
- Skelton JA, Croyle RT: Mental Representation in Health and Illness. New York, NY, Springer-Verlag, 1991
- Cameron L, Leventhal EA, Leventhal H: Symptom representations and affect as determinants of care seeking in a community-dwelling, adult sample population. *Health Psychol* 12:171-179, 1993
- Horne R: Treatment perceptions and self-regulation, in Cameron LD, Leventhal H (eds): *The Self-Regulation of Health and Illness Behavior*. New York, NY, Routledge, 2003, pp 138-153
- Helman CG: *Culture, Health and Illness* (ed 3). Oxford, United Kingdom, Butterworth Heinemann, 1994
- Leventhal H: Health psychology: Past, present, and future. *Eur Health Psychol* 1:3-5, 2005
- Leventhal H, Leventhal E, Cameron LD: Representations, procedures, and affect in illness self-regulation: A perceptual-cognitive approach, in Baum A, Revenson T, Singer J (eds): *Handbook of Health Psychology*. New York, NY, Erlbaum, 2001, pp 19-48
- Baumann LC: Culture and illness representation, in Cameron LD, Leventhal H (eds): *The Self-Regulation of Health and Illness Behavior*. New York, NY, Routledge, 2003, pp 242-254
- Hale ED, Treharne GJ, Kitas GD: The common-sense model of self-regulation of health and illness: How can we use it to understand and respond to our patients' needs? *Rheumatology* 46:904-906, 2007
- Rao JK, Anderson LA, Inui TS, et al: Communications interventions make a difference in conversations between physicians and patients: A systematic review of the evidence. *Med Care* 45:340-349, 2007
- Uitterhoeve RJ, Bensing JM, Grol RP, et al: The effect of communication skills training on patient outcomes in cancer care: A systematic review of the literature. *Eur J Cancer Care (Engl)* 19:442-457, 2010
- Barth J, Lannen P: Efficacy of communication skills training courses in oncology: A systematic review and meta-analysis. *Ann Oncol* 22:1030-1040, 2011
- Merckaert I, Libert Y, Razavi D: Communication skills training and research: The Brussels experience, in Kissane DW, Bultz BD, Butow PN, et al (eds): *Handbook of Communication in Oncology and Palliative Care*. Oxford, United Kingdom, Oxford University Press, 2011, pp 671-680
- Stiefel F, Bernhard J, Bianchi G, et al: The Swiss model, in Kissane DW, Bultz BD, Butow PN, et al (eds): *Handbook of Communication in Oncology and Palliative Care*. Oxford, United Kingdom, Oxford University Press, 2011, pp 641-648
- Fallowfield L, Jenkins V, Farewell V, et al: Efficacy of a Cancer Research UK communication skills training model for oncologists: A randomized controlled trial. *Lancet* 359:650-656, 2002
- Razavi D, Merckaert I, Marchal S, et al: How to optimize physicians' communication skills in cancer care: Results of a randomized study assessing the usefulness of posttraining consolidation workshops. *J Clin Oncol* 21:3141-3149, 2003
- Back AL, Arnold RM, Baile WF, et al: Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. *Arch Intern Med* 167:453-460, 2007
- Dunn SM: The art of teaching communication skills, in Kissane DW, Bultz BD, Butow PN, et al (eds): *Handbook of Communication in Oncology and Palliative Care*. Oxford, United Kingdom, Oxford University Press, 2010, pp 13-25
- Maguire P, Fairbairn S, Fletcher C: Consultation skills of young doctors: I—Benefits of feedback training in interviewing as students persists. *BMJ* 292:1573-1576, 1986
- Heinrich P: The role of the actor in medical education, in Kissane DW, Bultz BD, Butow PN, et al (eds): *Handbook of Communication in Oncology and Palliative Care*. Oxford, United Kingdom, Oxford University Press, 2010, pp 607-617

38. Margolis E, Soldatenko M, Acker S, et al: Peekaboo: Hiding and outing the curriculum, in Margolis E (ed): *The Hidden Curriculum in Higher Education*. New York, NY, Routledge, 2001, pp 1-20
39. Brown RF, Bylund CL, Kissane DW: Principles of communication skills training in cancer care, in Holland JH (ed): *Psycho-Oncology* (ed 2). New York, NY, Oxford University Press, 2010, pp 597-604
40. Bylund CL, Brown RF, di Ciccone BL, et al: Training faculty to facilitate communication skills training: Development and evaluation of a workshop. *Patient Educ Couns* 70:430-436, 2008
41. Hafferty FW: Beyond curriculum reform: Confronting medicine's hidden curriculum. *Acad Med* 73:403-407, 1998
42. Bylund CL, Brown RF, Lubrano di Ciccone B, et al: Facilitating skills practice in communication role play sessions: Essential elements and training facilitators, in Kissane D, Bultz BD, Butow PM, et al (eds): *Handbook of Communication in Cancer and Palliative Care*. Oxford, United Kingdom, Oxford University Press, 2010, pp 597-606
43. Bylund CL, Brown RF, Lubrano di Ciccone B, et al: Assessing facilitator competence in a comprehensive communication skills training programme. *Med Educ* 43:342-349, 2009
44. Kirkpatrick DL: Evaluation of training, in Craig R, Bittle I (eds): *Training and Development Handbook*. New York, NY, McGraw Hill, 1967
45. Konopasek L, Rosenbaum M, Encandela J, et al: Evaluating communication skills training courses, in Kissane DW, Bultz BD, Butow PN, et al (eds): *Handbook of Communication in Oncology and Palliative Care*. Oxford, United Kingdom, Oxford University Press, 2010, pp 683-693
46. Bylund CL, Brown R, Gueguen JA, et al: The implementation and assessment of a comprehensive communication skills training curriculum for oncologists. *Psychooncology* 19:583-593, 2010



Announcing *JCO*'s New Rapid Review Program

Journal of Clinical Oncology (*JCO*) announces a new Rapid Review program for original research articles deemed to be of high interest to our clinical and translational readership.

The *JCO* Rapid Review program will select those articles that have the most practice-changing or time-dependent research implications and fast-track them for acceptance decisions and subsequent online publication. In addition, in an effort to provide the widest possible dissemination of the manuscripts chosen for the program, all Rapid Review articles will be published on *JCO* online without access controls.

For more information, or to submit a manuscript, please visit submit.jco.org, or contact the *JCO* Editorial office at jco@asco.org.



American Society of Clinical Oncology