Support Care Cancer (2000) 8:40–45
DOI 10.1007/s005209900067

ORIGINAL ARTICLE

L. Grassi
T. Giraldi
E. G. Messina
K. Magnani
E. Valle
G. Cartei

Physicians' attitudes to and problems with truth-telling to cancer patients

Published online: 22 July 1999

L. Grassi (✉)
Clinica Psichiatrica Università di Ferrara, Arcispedale S. Anna, C.so Giovecca 203, I-44100 Ferrara, Italy
e-mail: L.grassi@dns.unife.it
Tel.: +39-0532-236809
Fax: +39-0532-212240

L. Grassi M.D. · K. Magnani · Ph.D.
Department of Medical Sciences of Communication and Behavior, Section of Psychiatry, the Consultation-Liaison Psychiatry Service and Psycho-Oncology Unit, University of Ferrara, Italy

T. Giraldi, Ph.D.
Department of Biomedical Sciences, Section of Pharmacology, University of Trieste, Italy

E.G. Messina, Ph.D.
Memorial Sloan-Kettering Cancer Center, Cornell University Medical Center, New York, USA

E. Valle, M.D.
Health Direction, Santa Maria della Misericordia Hospital, Udine, Italy

G. Cartei, M.D.
Division of Medical Oncology, Santa Maria della Misericordia Hospital, Udine, Italy

Abstract Disclosure of a diagnosis of cancer to patients is a major problem among physicians in Italy. The aim of the study was to assess physicians' attitudes to and opinions about disclosure. A convenience sample of 675 physicians in Udine (North Italy) completed a ten-item questionnaire. About 45% indicated that, in principle, patients should always be informed of the diagnosis, but only 25% reported that they always disclosed the diagnosis in practice. Physicians with a surgical specialization employed in general hospitals endorsed disclosure of the diagnosis more frequently than GPs and older physicians. One third of the responding physicians persist in the belief that the patients never want to know the truth. Hospital doctors considered the hospital, rather than the patient's home, was the most appropriate place to inform the patients. The opposite result was found among GPs. Almost all the physicians endorsed the involvement of family members when disclosing the diagnosis, but, at the same time they also indicated that families usually prefer their ill relative not to be informed. Ninety-five per cent of physicians believed that the GP should always be involved in the processes of diagnosis and communication, and 48% indicated that the GP should communicate the diagnosis to the patient (as opposed to the physician who made the diagnosis). Having guidelines for breaking bad news to patients was indicated as an important need by 86% of the responding physicians. Despite changes in medical education, improvement of communication skills in dealing with cancer patients and their families represents an important need in healthcare settings.

Key words Cancer diagnosis · Communication · Physicians' opinions

Introduction

Although emerging research reveals some signs of change in southern Europe (e.g. Italy, Spain and Greece) in the traditional medical practice of non-disclosure of cancer diagnosis and prognosis to the patients affected [1–8], the problem of communication in oncology is far from solved. As far as Italy is concerned, a high proportion of cancer patients continue to receive inadequate information about their illness. Studies conducted over the last decade have reported that 53–64% of cancer patients surveyed had not received sufficient information about their diagnosis or their treatment options [1, 3, 9], particularly those in an advanced phase of illness [10]. These data seem to indicate that, in general, opinions among Italian physicians are still comparable to those reported from the US in

the 1960s [11] and that they are clearly less in favor of disclosure than other Western or Northern European countries [12, 13].

The conflict inherent in the shift towards greater openness toward patients about their diagnosis is reflected in part in the paternalistic doctor–patient relationship [14] and in part in the differing perspectives and wishes of patients and families regarding disclosure and nondisclosure. Studies have demonstrated that the traditional practice of giving family members information not given to patients is a source of conflict for physicians, patients and relatives. For example, Arraras et al. [15] found that 90% of noncancer patients surveyed would want complete or partial knowledge of their cancer diagnosis, yet 70% of that same sample also indicated they would prefer that information about the diagnosis be withheld from a relative who had cancer. In a survey that explored the dominant communication practices regarding disclosure among physicians who were enrolled in a bioethics course, Gordon and Paci [16] found that less than half (44%) of all responding physicians would inform patients of the cancer diagnosis and their prognosis if the patient wanted to know but the family members were opposed to the patient's knowing.

The problem is made even more complex by the fact that not only oncologists, but many health professionals are involved with the patient and his/her family during the diagnostic and therapeutic processes of the illness (e.g. surgeons, radiotherapists, physiotherapists). The recent establishment in Italy, as in other parts of Europe, of palliative home care services provided by GPs for assistance to homebound advanced cancer patients and for support for their families gives a major role to primary care physicians in this area [17]. In contrast to the experience in other European countries [18–22], physicians' inhibitions about disclosing information to cancer patients and communications skills for health professionals have not been the objects of research and training in Italy.

The aim of the present study was to assess physicians' attitudes to disclosure of the diagnosis of cancer and to identify physician-related barriers to disclosure.

Methods

A ten-item self-administered questionnaire assessing attitudes to and problems in disclosure of a diagnosis of cancer to patients was mailed to a convenience sample of physicians in the province of Udine, North Italy. The questionnaire investigates some common aspects of disclosing the cancer diagnosis, such as actual attitudes to and practices in disclosure among physicians, family involvement during the disclosure process, physicians' opinions about the best place for disclosure and their attitudes to guidelines on breaking bad news.

The data were analyzed using the SPSS for Windows software [23]. The percentages are referred to the actual responses. Statistical procedures included descriptive statistics, frequency counts, cross-tabulation and the Chi-square test, with a level of significance set at $P<0.05$.

Results

A total of 675 out of 1,245 physicians returned the questionnaire (response rate = 54.21%). These were 497 male (74.7%) and 167 female (25.1%) physicians, with a mean age of 44.7 ± 11.9 years (range 23–75). Over half had a specialist qualification in surgery ($n=360$, 54.1%), 154 (23.2%) were qualified in internal medicine, including oncology ($n=22$) and 151 (22.7%) had no specialist qualification. About half worked in hospitals ($n=330$, 48.9%), 210 were GPs (31.1%), 45 (6.6%) worked in specialist health services and 90 (13.3%) in other public or private health services. The distributions of the physicians' responses to the questionnaire items are listed in Table 1.

Disclosure attitudes and practices

Less than half of all responding physicians (44.8%) said that, in principle, the patient 'should be always told' the diagnosis, and 46.6% said that the patient should be told the truth 'only in some cases.' Physicians working in hospitals were more likely than GPs to endorse the view that, in principle, the diagnosis should be always disclosed to the patient (52.9% vs. 34.1%, (chi-square = 17.27, *d.f.*, 1, $P<0.001$). Regarding reported practices, 25.4% of the physicians said that they 'always disclosed the diagnosis', 52.2% said they disclosed it 'only in some cases', and 18% said they disclose the diagnosis 'only in part.' Surgeons (29.2%) were more likely to 'always' disclose the diagnosis than were physicians without any subspecialty (19%; chi-square = 5.07, *d.f.* 1, $P<0.05$). Moreover, GPs (16.8%) were less likely to 'always' disclose the diagnosis to the patient than were physicians employed in a general hospital (30.7%; chi-square = 12.15, *d.f.* 1, $P<0.001$). Physicians in the age range 60–70 years were also less likely than younger physicians (age range 30–40) to 'always' disclose the diagnosis (15.1% vs 29%, chi-square = 4.84, *d.f.* 1, $P<0.02$). Over half of the physicians believe, based on their clinical experience, that patients wish to know the truth (55%); however, 31.4% of the physicians disagreed with this statement. There were significant differences between GPs and physicians working in the hospital environment in their attitudes to the idea that 'patients wish to know the truth' (46.6% GPs v. 61.1% hospital physicians, chi-square = 10.12, *d.f.* 1, $P<0.001$). In addition, older physicians were more likely to state that 'patients do not wish to know the truth' than younger ones (chi-square = 22.3, *d.f.* 5, $P=0.01$). Fifty-six per cent (56%) of

Table 1 Distribution of physicians' opinions and attitudes about disclosing the diagnosis to cancer patients

I believe that the diagnosis	
Should be always told	44.8%
Should be told only in some cases	46.6%
Should be told in part	7.4%
Should never be told	0.8%
No answer	0.5%
In my clinical practice I tell my patients the truth	
Always	25.4%
Just in some cases	52.2%
Just in part	18%
Never	1.5%
No answer	0.4%
In my clinical experience, the patients wish to know the truth	
Yes	55%
No	31.4%
No answer	13.6%
I believe it is useful to involve the family when disclosing the diagnosis	
Yes	93.2%
No	5.6%
No answer	1.2%
In general family members ask me not to inform the patient about the diagnosis	
Yes	85.4%
No	8.6%
No answer	6.1%
The patient's age is a key factor in deciding whether or not to disclose the diagnosis	
Yes	56.8%
No	41.1%
No answer	2.1%
I believe that the truth should be told to the patient by	
His/her GP	48.6%
The doctor who makes the diagnosis	31%
The oncologist	11.9%
Others	4.2%
No answer	4.4%
The patient's GP should be involved	
Always, in communicating the diagnosis and in treatment	95%
After the patient has been told about the diagnosis	3.3%
No answer	0.2%
I prefer to communicate the diagnosis	
At the patient's home	16.1%
In the hospital	35%
No answer	48.9%
I would like to have guidelines on how to break bad news	
Yes	86.5%
No	13.4%
No answer	0.2%

the physicians said that patient's age is a key factor in their decision regarding disclosure; 41% said that this was not a significant factor in their decisions on disclosure.

Family involvement and disclosure

Although most physicians (93.2%) considered it useful to involve the family when disclosing the diagnosis to the patient, 85.4% of the doctors said that the family usually asks the physician not to disclose the diagnosis to the patient. GPs reported more often than physicians employed in general hospitals that family members asked them not to disclose the diagnosis to the patient (GPs 92.3% vs hospital doctors 84%, (chi-square = 7.07, *d.f.* 1, $P < 0.01$).

Disclosure and the general practitioner

There was general agreement (95%) in that the patient's GP should always be involved in the diagnostic and therapeutic program. Nevertheless, there were differences about 'who should communicate the diagnosis to the patient.' Forty-eight per cent of the responding physicians said that the 'truth' should be communicated to the patient by the patient's GP, 31% said the truth should be communicated to the patient by the physician who makes the diagnosis, and 11% said the truth should be communicated to the patient by the oncologist. There were differences among GPs and hospital physicians on this item, with most GPs (73.6%) indicating that the general practitioner should communicate the diagnosis to the patient and 45.1% of the hospital physicians endorsing the view that the first doctor who makes the diagnosis should inform the patient (chi-square = 84.44, *d.f.* 3, $P < 0.001$).

Attitudes to place of disclosure

Slightly less than half of the sample (48.9%) did not express any preference about 'where' to communicate the diagnosis; 35% indicated that the hospital is the most appropriate place to communicate the diagnosis to the patient; while 16.1% of the responding physicians indicated that the patient's home was the most appropriate place. GPs (25%) were more likely than hospital physicians (16%) to communicate the diagnosis to the patient in the patient's home (chi-square = 120.9, *d.f.* 1, $P < 0.001$), while more hospital physicians than GPs thought communication of the diagnosis in the hospital was preferable (74.6% vs 18.7%, chi-square = 15, *d.f.* 1, $P < 0.001$).

Attitudes to guidelines

While there was general agreement (86.5%) among physicians that they were in need of guidelines to help them learn to communicate 'bad news' to patients, Chi-square tests revealed that fewer of the older doctors expressed a need for such guidelines (chi-square = 17.36, *d.f.* 5, $P < 0.01$).

Discussion

The study investigated attitudes to and problems in disclosing the diagnosis of cancer to the patients affected among a sample of North Italian physicians.

One of the first observations to emerge was that there was a contrast between the physicians' general attitude about truth-telling and their routine practice in the clinical setting. While about half the sample indicated that, in principle, patients should always be informed of the diagnosis, only one quarter reported that they always disclosed the diagnosis in practice. In spite of the data showing that cancer patients' adjustment to illness and their satisfaction with their physicians are related to being given clear and full information in a supportive way [24–28], a high proportion of physicians (one third in this study) persist in the belief that patients 'never want to know the truth.' Certain attitudes to this issue were found to differ with the physician's age and professional activity. As expected, older physicians were less likely than younger physicians and those with a surgical specialty to disclose the diagnosis. Nevertheless, GPs were also less favorably disposed to disclosure of the diagnosis. These findings indicate that, in spite of the movement towards provision of more open information to cancer patients in different countries [12, 13], Italian physicians continue to have difficulties in communicating frankly with cancer patients.

One of the possible determinants of these findings is inherent in the difficult problem of dealing with the patient's family. Almost all physicians (93%) endorsed the involvement of family members when disclosing the diagnosis, but at the same time, they also indicated that families usually prefer their ill relative not to be informed of the diagnosis. This finding confirms that collusion is an extremely difficult problem and a major task for physicians. Whether this is a cultural problem or a result of the scarce attention to the family needs when a relative is diagnosed as suffering from cancer should be explored by future research. In fact, recent investigations have shown that the psychosocial consequences of cancer involve the whole family in a dramatic way, as documented by the high prevalence of psychological morbidity among cancer patients' relatives [29, 30]. Thus, the question of helping the families to cope with the emotional burden of being informed of the diagnosis and communicating with their ill relatives is one that should be addressed as a matter of urgency.

The question about who should give the diagnosis elicited the assignment of this role to the primary care physician as an important result of the present study. In fact, most physicians endorsed the view that the GP should always be involved in the diagnostic and therapeutic process, and half of the sample indicated that the GP, rather than those who made the diagnosis, should have the key role of communicating the diagnosis to his/her patient. This is in contrast with data from Italian studies showing that only 10–16% of patients who were informed of their diagnosis had learned of it from their GPs, while the majority had obtained the information from the surgeons [2, 3], or, as also reported from non-Italian studies [31], by means of their own research. However, this result points out the important role of primary care physicians in cancer settings, also in view of their direct involvement in home palliative care services for terminally ill patients.

As far as where the information should be given, half of the sample of physicians did not express any preference. Of the remaining physicians, GPs tended to prefer the patient's home, whereas hospital doctors considered the hospital was the most appropriate place to inform the patients.

Lastly, the need for improving communication skills was a further point in this study. The majority of physicians endorsed the idea of having guidelines on 'breaking bad news' to their patients. This result reflects the importance of how information should be given to the patients and how communication could be improved within a sound doctor–patient relationship. In fact, since in Italy, as in many other countries, specific training in this area is rarely provided by medical schools, physicians often depend on their experience, personal values and emotional status when making decisions on whether, when, where and how to disclose the diagnosis of cancer. The problem is made more complex, however, by the fact that providing physicians with guidelines [32] is not sufficient to modify their behavior permanently. In fact, attention to the style of communication and the proper place for the communication of bad news are still poor even in countries where information is routinely given to cancer patients [33, 34]. This confirms the fact that unadorned and unslanted information with no opportunity for the patients to disclose their own concerns may have limited effects, or even negative psychological consequences, upon the patients themselves [25, 35–37]. Taken together, these data suggest that setting up and implementing more specific communication skills courses within the medical curricula is the most urgent need both in Italy and in other countries [38, 39]. With reference to this, recent studies have shown that workshops on communication significantly reduced barriers and enhanced health professionals' abilities and effectiveness not only in providing patients and relatives with adequate information but also, and especially, in alleviating their concerns [40].

Certain caveats should be mentioned in relation to this study. First, physicians involved in this research are not representative of all Italian physicians and thus generalizability of the results is not permissible. Second, the questionnaire did not evaluate a number of variables that may be important in determining atti-

tudes about communication in oncology, such as work-related stress symptoms, experience with cancer in their own family, participation in training courses on psychological aspects of cancer and communication skills. Furthermore, as already mentioned, more empirical work is necessary to identify not only what ways of conveying bad news are most beneficial, but also whether how the news is conveyed accounts for variation in the adjustment to cancer [41].

Despite these limitations, the study indicates that communication of the diagnosis of cancer is still a complex problem in Italy and that further efforts are necessary to modify physicians' attitudes towards cancer patients and to enhance their communication skills in clinical practice.

References

1. GIVIO (1986) What doctors tell patients with breast cancer about diagnosis and treatment: findings from a study in general hospital. Br J Cancer 54:319–326
2. Mosconi P, Meyerowitz BE, Liberati CM, Liberati A (1991) Disclosure of breast cancer diagnosis: patient and physician report. Ann Oncol 2:273–280
3. Veronesi A, Busato C, Annunziata MA, Magri MD, Foladore S, Zanon M, Tumolo S, Monfardini S (1995) Prospective analysis of the information level of Italian cancer patients. Eur J Cancer [A] 31:425–426
4. Estapé, J, Palombo, H, Hernández, E, Daniels, M, Estapé, J, Grau, J, Viñolas, JJ, Mañé, JM (1992) Cancer diagnosis disclosure in a Spanish hospital. Ann Oncol 3:451–454
5. Rodríguez-Marín J, López-Roig S, Pastor MA (1996) Doctors' decision-making on giving information to cancer patients. Psychol Health 11:839–844
6. Centeno-Cortes, Nunez-Olarte JM (1994) Questioning diagnosis disclosure in terminal cancer patients: a prospective study evaluating patients' responses. Palliat Med 8:39–44
7. Lavrentiadis G, Manos N, Chistakis J, Semeglou C (1988) The Greek cancer patient's knowledge and attitudes towards his diagnosis and prognosis. Psychother Psychosom 49:171–178
8. Mystadikou K, Liossi C, Vlachos L, Papadimitroiu J (1996) Disclosure of diagnostic information to cancer patients in Greece. Palliat Med 10:195–200
9. Morasso G, Alberisio A, Capelli M, Rossi C, Baracco G, Costantini M (1997) Illness awareness in cancer patients: a conceptual framework and a preliminary classification hypothesis. Psychooncology 6:212–217
10. Pronzato P, Bertelli G, Losardo P, Landucci M (1994) What do advanced cancer know of their disease. A report from Italy. Support Care Cancer 2:242–244
11. Oken D (1961) What to tell cancer patients. A study of medical attitudes. JAMA 175:1120–1128
12. Weil M, Smith M, Khayat D (1994) Truth-telling to cancer patients in the Western European context. Psychooncology 3:21–26
13. Loge JH, Kaasa S, Ekeberg O, Falkum E., Hytten K (1996) Attitudes towards informing the cancer patient – survey of Norwegian physicians. Eur J Cancer [A] 32:1344–1348
14. Surbone A (1992) Truth telling to the patient. JAMA 268:1661–1666
15. Arraras JI, Illarramendi JJ, Valerdi JJ, James S (1995) Truth-telling to the patient in advanced cancer: family information filtering and prospect for change. Psychooncology 4:191–196
16. Gordon DR, Paci E (1997) Disclosure practices and cultural narratives: understanding concealment and silence around cancer in Tuscany, Italy. Soc Sci Med 44:1433–1452
17. Robinson L, Stracy R (1994) Palliative care in the community: setting practice guidelines for primary care teams. Br J Gen Pract 44:461–464
18. Maguire P, Faulkner A (1988) How to improve the counselling skills of doctors and nurses involved in cancer care. BMJ 297:847–849
19. Maguire P, Booth K, Elliott C, Jones B (1996) Helping health professionals involved in cancer care acquire key interviewing skill – the impact of workshops. Eur J Cancer [A] 32:1486–1489
20. Faulkner A (1994) Using simulators to aid the teaching of communication skills in cancer and palliative care. Patient Educ Counsel 23:125–129
21. Fallowfield L, Lipkin M, Hall A (1998) Teaching senior oncologists communication skills: results from phase I of a comprehensive longitudinal program in the United Kingdom. J Clin Oncol 16:1961–1968
22. Razavi D, Delvaux N (1997) Communication skills and psychological training in oncology. Eur J Cancer [A] 33 [Suppl 6]:S15–S21
23. Norusis MJ (1994) Statistical Package for the social sciences (SPSS) professional statistics-6.1. SPSS, Chicago.
24. Butow PN, Kazemi JN, Beeney LJ, Griffin AM, Dunn SM, Tattersall MHN (1996) When the diagnosis is cancer. Patient communication experiences and preferences. Cancer 77:2630–2637
25. Dunn SM, Patterson PU, Butow PN, Smartt HH, McCarthy WH, Tattersall HN (1993) Cancer by another name: a randomized trial of the effects of euphemism and uncertainty in communicating with cancer patients. J Clin Oncol 11:989–996
26. Derman U, Serbest P (1993) Cancer patients' awareness of disease and satisfaction with services: the influence of their general education level. J Cancer Educ 8:141–143
27. Paraskevaidis E, Kitchener HC, Walker LG (1993) Doctor–patient communication and subsequent mental health in women with gynaecological cancer. Psychooncology 2:195–200
28. Fallowfield L, Ford S, Lewis S (1995) No news is not good news: information preferences of patients with cancer. Psychooncology 4:197–202
29. Kissane DW, Bloch S, Burns WI, McKenzie D, Posterino M (1994) Psychological morbidity in the families of patients with cancer. Psychooncology 3:47–56
30. Harrison J, Haddad P, Maguire P (1995) The impact of cancer on key relatives: a comparison of relative and patient concerns. Eur J Cancer 31:1736–1740
31. Manfredi C, Czaja R, Price J, Buis M, Janiszewski R (1993) cancer patients' search for information. JNCI Monogr 14:93–104
32. Girgis A, Sanson-Fisher W (1995) Breaking bad news: consensus guidelines for medical practitioners. J Clin Oncol 13:2449–2456

33. Lind SE, Del Vecchio Good M-J, Seidel S, Csordas T (1989) Good BJ (1989) Telling the diagnosis of cancer. J Clin Oncol 7:583–589
34. Loge JH, Kaasa S, Hytten K (1997) Disclosing the cancer diagnosis: the patients' experiences. Eur J Cancer 33:878–882
35. Sardell AN, Trierweiler SJ (1993) Disclosing the cancer diagnosis. Procedures that influence patient hopefulness. Cancer 72:3355–3365
36. Maguire P, Faulkner A, Booth K, Elliott C, Hillier V (1996) Helping cancer patients disclose their concerns. Eur J Cancer [A] 32:78–81
37. Maguire P (1998) Breaking bad news. Eur J Surg Oncol 24:188–91
38. Walker LG (1996) Communication skills: when, not if, to teach. Eur J Cancer [A] 32:1457–1459
39. Campbell EM, Sanson-Fisher RW (1998) Breaking bad news. 3. Encouraging the adoption of best practices. Behav Med 24:73–80
40. Parle M, Maguire P, Heaven C (1997) The development of a training model to improve health professionals skill, self-efficacy and outcome expectancies when communicating with cancer patients. Soc Sci Med 44:231–240
41. Ptacek JT, Eberhardt TL (1996) Breaking bad news. A review of the literature. JAMA 276:496–502