

## Disclosure of cancer diagnosis: the Greek experience

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### Summary

**Purpose:** To analyze the attitude of Greek health professionals towards truth disclosure and factors that may influence it.

**Methods:** Through a self-completed questionnaire, we studied the attitudes over the initial disclosure of cancer diagnosis to cancer patients of 132 doctors and 123 nurses, partly involved in cancer patients' care, in 5 general hospitals of Crete, Greece.

**Results:** Eighty-nine percent of the participants considered information as patient's right and 88% as professional's ethical duty, 64% believed that the whole truth should be revealed, 90% avoided the word "cancer" in the communication and 39% disclosed cancer diagnosis at patient's direct asking. Respondents informed 1/10 of their new cancer patients, mainly due to perceived limited responsibility (23%), patient's low cognitive state (22%), fear of harming the patient (17%) and relatives' objection (15%).

Sixteen percent of fellows acknowledged to themselves the responsibility to inform patients. Cooperation, compliance and arrangement of patient's personal issues were considered as benefits from accurate disclosure (88%, 83% and 75%, respectively), the latter more among doctors than nurses ( $p=0.01$ ) and medical than surgical professionals ( $p=0.03$ ). Thirty-six percent of the respondents considered the presence of a psychologist necessary during disclosure, nurses more than doctors ( $p<0.001$ ).

**Conclusion:** Despite adequate theoretical background, Greek non-cancer specialists, doctors and nurses, initially inform accurately a small part of their cancer patients. Appropriate training programs for doctors and non-medical health professionals involved in cancer patients' management are required to upgrade professional-patient communication.

**Key words:** cancer, Greek health professionals' attitude, truth disclosure

### Introduction

Patient's consent is based on truth disclosure [1]. By the late 1970s, in Western countries, full disclosure of cancer diagnosis had become the norm [2].

The Greek Constitution (2001) supports the citizens' right on information that can be limited only when national security, legality and personal rights are jeopardized. In the Greek Penal Code (1998), truth concealment remains a debatable legal/medical issue, considered either as a doctor's offence or privilege, based on medical reasons.

Medical Ethics in Greece (2005) state that patients have the right to receive full information for their condition in accordance to local/individual culture. This right can be exceptionally restricted when it puts a patient's life or health in serious danger. Only doctors but never nurses or other non-medical professionals are entitled to inform patients, occasionally assisted by a psychologist or social worker. Depriving patients from information represents an independent disciplinary offence against patients' personality and dignity. Complete truth disclosure is not obligatory. The patient determines the extent of information

according to his/her interests and width of questions, having the right not to be informed but the obligation to determine deputy and clarify denial or consent to medical recommendations.

Bad news is any information that changes a person's view of the future in a negative way [3]. Rights and obligations concerning breaking bad news to a cancer patient repeatedly put professionals in dilemmas [4]. This is because ethics of information is not standardized all along health-care. In principle, the attending physician, avoiding harming, should focus on the relevant truth for the patient's proper care and planning his/her life in a holistic approach [5].

Studies regarding Greek health professionals, from 1980 to 2002, show that the attitude towards truth-telling to cancer patients has changed [4, 6-8]. Initial reluctance was attributed to insufficient training on communication skills, which lessens the patients' and professionals' distress [9-11] to family objections and lack of psychological support of both patients and professionals [5]. The situation also changed among patients [12], most of them being aware of their diagnosis, but up until recently, 59% not knowing their true diagnosis [13].

Greek doctors and nurses dealing with cancer patients have not been exposed to formal training on medical ethics and on breaking bad news.

In such an environment, we studied the attitude of Greek doctors and nurses on informing new cancer patients in 5 general hospitals of Crete, Greece.

## Methods

Doctors and nurses, partly involved in cancer patients' care, from 5 general hospitals in Crete, Greece, were included in the present survey.

A self-completed questionnaire (appendix 1) was specially structured to assess main issues of initial truth disclosure of diagnosis and prognosis to cancer patients. Multiple choice questions were provided and grouped in 6 categories: (I). Rights and obligations of patients and health professionals; (II). Benefits to patients and professionals from the disclosure; (III). Technical parameters of information; (IV). Factors influencing truth disclosure; (V). Quantitative parameters; (VI). Participants' characteristics.

Respondents had to choose among answering options by ticking, numbering, writing simple words or short phrases. Answering words or phrases were to be grouped and coded, afterwards.

Prior to its distribution, the questionnaire was pre-tested on 5 senior and 5 young doctors, 3 nurses and 3 clinical psychologists. Its final version was ap-

proved by the ethical committees of the participating institutions.

From January to June 2009, we distributed 264 questionnaires along with a cover letter explaining the eligibility criteria for participation and instructions on how to complete the form.

## Statistics

Continuous variables were tested for normality using the Kolmogorov-Smirnov test. Means-standard deviations or medians-interquartile range were calculated for continuous variables as appropriate. Frequencies and percentages were calculated for categorical variables. Continuous variables were analyzed using independent sample t-test, or Mann-Whitney U test as appropriate. Categorical variables were analyzed using chi-square test or Fisher's exact test. Significance was accepted as a two-sided p value <0.05.

## Results

During the 6-month study period, 255/264 (98%) completed questionnaires were collected.

Table 1 shows the respondents' characteristics. One hundred thirty-two doctors (58% males) and 123 nurses (89% females) responded.

Over the year 2008, prior to their response, 87% stated that they were involved in the management of cancer patients, with a median number of patients 55 (range 2-250) for each doctor, and 20 (range 1-200) for each nurse. Thirteen percent reported no such activity.

The answers are presented from the whole sample. Few differences emerged from comparison of different groups of participants and are presented where appropriate.

**Table 1.** Respondents' characteristics

Characteristics	Doctors (N=132) %	Nurses (N=123) %
Gender		
Males	58	4
Females	29	89
Not answered	13	6.5
Sector		
Surgical	35	37
Medical	50	44
Not answered	16	19
New cancer patients seen in 2008		
None	14	12
1-20	58	41
>20	28	27
Years on profession		
Not answered	20	30
Median (range)	5 (1-37)	17 (1-35)

**Table 2.** Rights and obligations

Answers (in parenthesis, number of options to choose)	%
Informing a patient, asking after, is (>1)	
a professional's ethical duty	88
a professional's penal/civic duty	33
Informing a patient, not asking after, is (>1)	
a professional's ethical offence	70
a professional's penal/civic offence	22
A cancer patient should know (1)	
the whole truth	64
part of the truth	33
not answered	3

**Table 3.** Subjects and responsibilities

Answers (in parenthesis, number of options to choose)	%
Which determines the information is (1)	
the doctor	62
the patient's relatives/the patient	32
other	6
In case that is the doctor, this should be (1)	
the close/attending doctor	69
the oncologist	21
other	6
not answered	4
Within a hierarchy, which determines the information is (>1)	
the senior doctor	88
the fellow	12

**Table 4.** Information: What for?

Answers (in parenthesis, number of options to choose)	%
Benefits from information would be (>1)	
Patient-professional cooperation	88
Patient's compliance	82
Arrangement of patient's personal issues	75
Avoidance of repeated questions	37
Other	14
Information wouldn't benefit anyone	11

"To be informed" was considered as patient's right by 89%, as patient's obligation by 6% and as not needed by 4% of the participants.

Table 2 shows the informational obligations of the professionals. Eighty-eight percent considered "informing a patient who is asking" as professional's ethical obligation and 33% as penal/civic duty, while 70% considered "informing a patient who isn't asking" as professional's ethical obligation, 22% as penal/civic offence and 12% as none of the above.

Sixty-four percent considered that the whole

**Table 5.** Technical aspects of information

Answers (in parenthesis, number of options to choose)	%
On information, patient is accompanied by (>1)	
Those he/she prefers	78
His/her relatives	65
Psychologist	36
The preferred way of disclosure would be (1)	
The doctor stating, first, and patient asking	66
The doctor encouraging the patient to ask	32
Other way	1
Not answered	1
The terms to be avoided on communication (>1)	
Cancer	90
Tumor	58
Other	36

**Table 6.** Factors that influence information

Answers (in parenthesis, number of options to choose)	%
The harder part of information to deal with would be (>1)	
Prognosis	48
Malignant nature of disease	35
Metastatic disease	24
Treatment (radio- and/or chemotherapy)	5
Factors negatively influencing truth-telling would be (>1)	
Patient's bad physical condition	63
Low cognitive/educational status	50/31
Age >75 years	31
Disease fatality/short survival	63/57
Low effectiveness of treatment	44
Relatives, against patient's information	45

truth should be revealed to the patient.

Table 3 shows the responsibilities of the subjects involved in patient's information. Sixty-two percent considered the doctor (21%, the oncologist) and 32% the patient and relatives as the persons responsible for determining the level of the information to be given. Nurses neither considered themselves nor were considered by the doctors as being entitled to provide such information.

Table 4 shows the benefits anticipated from information. These were patient-professional cooperation (88%), patient's compliance (82%), arrangement of patient's pending personal issues (75%), avoidance of repeated questions (37%), and others (control of emotions, participation in therapeutic decisions, better coping with treatment problems, change of lifestyle, understanding of symptoms and trust in doctor), at a sum of 14%, while 11% considered truth disclosure as non beneficial.

Table 5 shows technical aspects of the provided information. The office was considered as the best place for informing the patient. As persons to accompany the patient upon information, 78% considered those the patient prefers, 65% the relatives and 36% the psychologist.

As preferred way of truth disclosure, 66% considered the doctor providing the relevant information first, and answering patient's questions thereafter. On communication, 90% would avoid the term "cancer" and 58% the term "tumor".

Table 6 shows factors influencing information. As the first harder part of information to deal with, 48% graded prognosis, 35% malignant nature and 24% dissemination of the disease. As factors negatively influencing truth telling, 63% considered patient's bad physical state, 63% disease fatality, 50% patient's low cognitive state and 45% family's objections.

Table 7 shows what participants would answer to a patient asking "Am I getting cancer?". Eleven percent stated "I don't know". Among provided answers, 33% of the participants chose "I'm afraid, you are", 23% "Perhaps, you are", 9% "Probably, you aren't", and 2% "You aren't", while 22% chose answers different than the ones provided, revealing the truth at 6%, and summing immediate truth disclosure at 39%.

Respondents used to inform only 1/10 of their new patients. Ninety of them (35%) attributed this rate to 24 reasons, shown in Table 8, these mainly being limited responsibility (23%), low patient's cognitive state (22%), fear of harming the patient (17%) and the relatives' objections (15%).

We compared the respondents' answers by gender and profession parameters (doctor/nurse, surgical/medical sector, seniority and rate of exposure to cancer patients' care). Eight answers of varying interest differed significantly: (1) Psychologist to be present on information, more among females than males (87 vs 76%,  $p=0.03$ ) and nurses than doctors (48 vs 24%,  $p<0.001$ ); (2)

Junior doctors to undertake information, supported more among doctors than nurses (63 vs 10%,  $p<0.001$ ); (3) Arrangement of patient's pending personal issues as benefit of information, an answer provided more among doctors than nurses (86 vs 72%,  $p=0.01$ ) and medical than surgical professionals (82 vs 70%,  $p=0.03$ ); (4) "Cancer" to be avoided on communication, a more common answer among females than males (46 vs 22%,  $p<0.001$ ) and doctors than nurses (96 vs 82%,  $p<0.001$ ); (5) The whole truth to be revealed was supported more among young than senior doctors (72 vs 54%,  $p=0.047$ ); (6) The director to determine the amount of truth to be told, more among nurses than doctors (64 vs 14%,  $p<0.001$ ); (7) The doctor stating first, and patient asking thereafter, as preferred way of information was supported more among medical than surgical professionals (88 vs 70%,  $p<0.001$ ); and (8) Disease fatality as negatively influencing information, an answer provided more among young than senior doctors (66 vs 46%,  $p=0.035$ ).

## Discussion

Cancer patients are actually informed about various diagnoses of different nature and prognosis, while what is disclosed all along the disease course may not be represented by what is revealed initially. This process cannot be precisely simulated within questionnaires [4]. However, professionals' answers concerning attitude, patient's preferences and situational factors, are the best available reflection of the current practice.

Available studies involve palliative care specialists and Greek oncologists, members of the Greek Oncology Society, seated in Athens [4], as well as oncology nurses in Athens [8], while our survey involved clinicians and nurses from general hospitals, partly dealing with cancer patients' care, in the pe-

**Table 7.** A crucial point of information

Answers	%
To patient, asking: "Am I getting cancer?", the answer is	
"I'm afraid, you are"	33
"Perhaps, you are"	23
"Probably, you aren't"	9
"You aren't"	2
Other than provided*	22
Non-readiness to answer	11

\*For details see text

**Table 8.** Factors that deterred professionals to inform patients\*

Factors (>1 option to choose)	%
Patient's low cognitive state	22
Patient's old age	17
Patient's wish not to be informed/denial	9/5
Patient's bad physical condition	9
Professional's limited responsibility	23
Professional's fear of harming patient	17
Lack of support	7
Short expected survival	7
Relatives against patient's information	15
Others <sup>§</sup>	

\*90 participants responded; §14 different factors, each < 6% (see text)

riphery of our country, who responded at a high rate.

Our participants confirmed 4 fundamental issues:

1. *A patient has the right to be informed.* The majority of doctors and nurses acknowledged it, since difficulties in cancer patients' care that motivated feelings of futility, pessimism and denial mechanisms for truth disclosure have lessened [14].

In 1996, of 228 Greek cancer and palliative care specialists, 11% concealed diagnosis, 11% disclosed it to all, and 78% to some patients [4]. In 2002, of 148 Greek oncology nurses 75.7% believed that only some patients should know the truth [8]. In our survey, 96% of doctors and 97% of nurses, although not being cancer specialists, acknowledged a patient's right to know the truth (64%, the whole truth), and, theoretically, would disclose it more frequently than cancer specialists in the past. However, if they were directly asked by a patient "Am I getting cancer?", only 39% of doctors and 33% of nurses would disclose the diagnosis. It is unclear how much tactics or no readiness to face difficult questions attributed to this gap [15,16]. Although concealment protects [17], physicians are expected to be skilled to manage their own stress on breaking bad news [5]. Unskilled subjects experience more stress when they disclose than conceal cancer diagnosis [18]. In practice, a wider gap would be expected for nurses, as they aren't entitled and, subsequently, not exposed to the real challenge of disclosure. Greece is expected to shift toward the Western autonomy predicament, similar to other Mediterranean countries [19], although partial and non-disclosure still remain a reality.

2. *Only doctors and never nurses inform patient.* Indeed, no nurses considered themselves or were considered by doctors as eligible to inform a cancer patient.

Our participants were asked not who is informing but, almost similarly, who is determining the amount of information given to patients. A 62% instead of 100%, as that being the doctor, should not be interpreted as deviation from the rules. Thirty-two percent considered as that being the relatives and the patient himself. They indicated the close/attending doctor (69%), while in the medical hierarchy, the director (64%), with nurses significantly more than doctors (64 vs 14%). In the lack of formal teaching procedures in our hospitals, breaking bad news is considered as a matter of practising experi-

ence, being acknowledged to senior doctors. In addition, one fifth of the respondents preferred the oncologist, recognizing his/her relevant suitability and experience. An extra equanimity, that somebody else, as is the oncologist, will certainly undertake the awkward procedure of breaking bad news, cannot be excluded.

Fellows' responsibility to inform was recognized by the directors, but to a lesser extent by senior registrars, nurses and fellows themselves (7%, 10% and 16%, respectively). Directors seem open and senior registrars aware of young doctors' unsatisfied needs. As fellows ought to acquire this skill by practising on it, the situation favors the application of relevant training programs.

3. *A patient has the right to receive full information.* "Full" may mean "all available", "what the patient asks after", "that sates the patient to consent". The majority (64%) of our respondents considered the former. Young doctors significantly exceeded senior ones (72 vs 54%) in considering the whole truth to be revealed, opposing the literature data supporting that the physician isn't always able to judge solitarily when truth might harm the patient [ 20] and that awareness or suspicion of cancer diagnosis is related to psychiatric morbidity [21]. Young doctors are expected to tend to a modern viewing, with a supportive setting incorporated. However, dexterity of personalizing and timing of truth disclosure and handling its sequels are mostly a matter of training and practising experience, which, among young doctors, is under development.
4. *A patient determines the extent of information, according to his/her interests.* Our respondents approached this issue in two, seemingly opposed ways. Nine percent recognized the patient determining how much truth to hear, while 32% preferred the patient being encouraged to ask first, setting boundaries of information. Even if a patient, by asking, guides the doctor's answers, he will partly influence the amount of information offered, as the doctor, by answering, gives the necessary information, which might exceed what the patient considers as enough.

In addition, breaking bad news may necessitate multidisciplinary approach. Due to doctor-centered customs, only 36% of the respondents, more females than males (42 vs 22%) and nurses than doctors (48 vs 24%), considered that the doctor should be assisted by a psychologist.

Our nurses, mainly females, aren't exposed to patient's initial information, so they may fear a patient's reaction more than doctors and would prefer a psychologist handling an upsetting situation. This is in accordance with the patients' preference of setting emotional support and manner of communicating bad news [22].

5. *Truth concealment remains a doctor's offence or privilege, and depriving information, a disciplinary offence.* In our study, some data distinguish a professional's position facing patients who are or aren't seeking information. A non negligible percentage (13-20%) believed that, acting against a patient's will, is inducing legal offence. Indeed, legal obligations have been recognized to physicians [23]. In a study that included law and medical students, the former, respecting obligation more than an autonomous choice, significantly exceeded medical students in considering patients to be informed (35 vs 11.7% for diagnosis and 25.6 vs 7% for prognosis), even if they had expressed wish not to [24]. It seems that legal or medical professional orientation among students differentiates attitudes early without being certain whether these attitudes last through actual professional practice.

Unwillingness and denial were reported by our respondents at low rates (9 and 5%, respectively). To patient unwilling, denying or wrongly refusing to consent, one should reveal what is vital for an ethically sound medical decision [1], as the key thing is that the patient continues with proper treatment. Current practice of giving information cannot be regarded as evidence-based [15,16,25], and physicians are leant upon empirical guiding [15,16,22, 26]. Health professionals in Greece, as in many countries [27, 28], are not exposed to formal training on medical ethics and on breaking bad news to patients, but it is obvious that the theoretical background of our participants tends to the Western one, that favors truth disclosure. In 2002, 66.2% of Greek oncology nurses attributed additional reluctance to engage in open conversation with patients to no or non sufficient training on communication [8]. It is supposed that beside formal training procedures, informal ones and public education (through early cancer detection, lessening of perception that cancer is always a fatal disease, increase of treatment options and treatment success) have prepared an attitude to turn actual revealing of cancer diagnosis to proper rates [2,17]. In addition, Greek doctors and nurses attributed their reluctance to wishes of the family and lack of an easily available psychological support

of both patients and health professionals [4,8]. Our participants recalled 24 reasons for not informing, so the very small percentage (3%) of lack of training as being a causative factor, may seem reasonable, not neglecting a false impression that such skills are achieved, mainly by practising than teaching procedures [29,30].

Better outcome, decrease of anxiety, increased satisfaction and improved compliance are recognized as benefits from information [31,32]. Ten years ago, 11% of Greek, mainly oncology-oriented professionals [4,8], considered information as not being beneficial, but the rest acknowledged it as beneficial to the professional's good therapeutic relationship (71.6%) and peacefulness (37%), and patients' good therapeutic relationship (70%), better palliation and support (3%) [4,8]. Only 4-7% of our respondents considered information as not beneficial. Most of them recognized as extra benefit the patient's motivation to arrange pending personal issues (75%), significantly more doctors than nurses (86 vs 72%), and medical than surgical professionals (82 vs 70%). In our practice, medical professionals are exposed longer than surgical ones to disease course and to its sequels on the whole patient's life and family. Unfinished or unresolved business causes anxiety and distress that may lower the threshold of somatic symptoms and difficulties for relatives to resolve their grief [16]. This may make medical professional to respect more a patient life settlements.

When informing patients, most professionals would avoid the word "cancer", doctors more than nurses (96 vs 82%). A dilemma to come to terms with one's cancerous disease is rising when one is entitled to do and actually does it (i.e. the doctor) than does not (i.e. the nurse).

A direct way of revealing cancer diagnosis and prognosis [33] was more frequently considered as harder to deal with (1/3 vs. 1/20, and 1/2 vs. 1/4, respectively) than an indirect one. A bald way of stating diagnosis is distressing both for the patient and the doctor. Descriptions, metaphors and euphemisms smooth transition from health to a life-threatening disease [15]. Of our respondents, up to 36% would prefer descriptions, metaphors and euphemisms to communicate cancer diagnosis to patients.

Based on our respondents' attitude, we could conclude ways of interventions to improve health professional-patient communication:

Prepare professionals in facing difficult questions from patients and relatives.

Train young doctors on breaking bad news.

Spend more time with the patient, who, at first glance, seems as having cognitive difficulties. It takes time to correctly assess and even overcome

the patient's cognitive state before excluding him/her from information.

Encourage nurses to attend patient's information in order to stand more consistently with what has been revealed and what needs have emerged post-information.

Widen multidisciplinary team on and post-breaking bad news to approach and support patients and family, willing and accepting disclosure or not, as well as professionals.

It may not be necessary to reveal all at once, and if not being asked after, to avoid any bald way of

disclosing diagnosis at the initial approach.

The patient's motivation to arrange pending personal issues largely depending on the information given should not be neglected.

Until evidence-based way of information is achieved, health professionals can lean, though not unquestioningly, upon empirical guiding [34], and participate in training programs and research [29,30] directed towards not only description but also towards interventional studies to improve providers' skills as well as patients' outcome.

**Appendix 1**

QUESTIONNAIRE (To be answered by nurses or doctors, anonymous, please)

Dear colleague,  
 Suppose that you are about to initially inform a new cancer patient.  
 All therapeutic options have been defined.  
 Please, put your answers with a tic, a word or a short phrase, keeping the limitations mentioned in parentheses.

**PART 1. Rights and obligations.**

*A. Is informing a patient: (1 tic)*

- 1. A patient's right?
- 2. » obligation?
- 3. Not needed?
- 4. I don't know/answer

*B. Is informing a patient who is asking after: (up to 3 tics)*

- 1. A professional's ethical duty?
- 2. » civic duty?
- 3. » penal duty?
- 4. None of the above?
- 5. I don't know/ answer

*C. Is informing a patient who isn't asking after: (up to 3 tics)*

- 1. A professional's ethical offence?
- 2. » civic offence?
- 3. » penal offence?
- 4. None of the above?
- 5. I don't know/answer

*D. Should a patient know (1 tic):*

- 1. The whole truth?
- 2. Part of the truth?
- 3. None of the above?
- 4. I don't know/answer

*E. Who is determining the amount of information: (1 tic):*

- 1. The patient?
- 2. The doctor?
- 3. The nurse?
- 4. The psychologist?
- 5. The patient's relatives?
- 6. I don't know/answer

*F. If this is the doctor, who particularly: (1 tic):*

- 1. The family doctor?
- 2. The attending doctor?
- 3. The close doctor?
- 4. The oncologist?
- 5. Other? (to specify).....
- 6. I don't know/answer

*G. What doctor, among a medical hierarchy: (up to 3 tics):*

- 1. The fellow?
- 2. The registrar?
- 3. The director?
- 4. I don't know/answer

**PART 2. Information. What for?**

*A. How truth disclosure could benefit the patient: (up to 3 tics):*

- 1. Inducing cooperation?
- 2. Motivating personal arrangements?
- 3. Other? (to specify).....
- 4. It couldn't benefit
- 5. I don't know/answer



B. How truth disclosure could benefit the professional: (up to 3 tics):

- 1. Patient's compliance?
- 2. Patient's satisfaction?
- 3. Other? (to specify).....
- 4. It couldn't benefit
- 5. I don't know/answer

PART 3. Technical issues of information

A. What is the best place for informing the patient: (1 tic)

- 1. The wardroom?
- 2. The office?
- 3. Other? (to specify).....

B. Who should accompany the patient: (up to 8 tics)

- 1. Those the patient prefers?
- 2. Patient's relatives?
- 3. Patient's attending doctor?
- 4. Nurse?
- 5. Psychologist?
- 6. Civil worker?
- 7. Family doctor?
- 8. Other? (to specify).....
- 9. I don't know/answer

C. What way of disclosure would you choose: (1 tic)

- 1. Encourage patient to ask questions, determining extent of information?
- 2. State what you think appropriate, with patient asking additional questions?
- 3. Other way? (to specify).....
- 4. I don't know/answer

D. What terms would you avoid, on communication: (up to 10 tics)

- 1. Aggregation of abnormal cell?
- 2. Cancer?
- 3. Enlargement?
- 4. Irritation/ inflammation?
- 5. Lesion?
- 6. Mass?
- 7. Neoplasm?
- 8. Shadow?
- 9. Tumour?
- 10. Other? (to specify).....

E. What part of information do you find hard to deal with:

(grade all:1=the most, 2, 3, 4=the least):

- 1. The malignant nature of the disease?
- 2. That the disease is metastatic?
- 3. That radio- or chemotherapy is needed?
- 4. The poor prognosis?
- 5. I don't know/answer

F. What would you answer to a patient's question "Am I getting cancer?" (1 tic)

- 1. You aren't
- 2. Probably, not
- 3. Perhaps, you are
- 4. I'm afraid, you are
- 5. Other? (to specify).....
- 6. I don't know/answer

PART 4. Factors that influence information

A. What factors would negatively influence your truth telling: (up to 13 ticks)

- 1. Patient's age >75 years?
- 2. » bad physical condition?
- 3. » low cognitive level?
- 4. » low educational level?
- 5. » bad family status?
- 6. » bad occupational status?
- 7. » bad social status?
- 8. » relatives, negative for informing the patient?
- 9. Disease fatality?
- 10. Short expected survival?
- 11. Treatment of low activity/effectiveness?
- 12. » , non- prolonging survival?
- 13. I don't know/answer

PART 5. Quantitative and other parameters

A. How many newly diagnosed cancer patients have you dealt with, over theast 12 months?

B. How many of the above patients did you inform?

C. What parameters deterred you from informing them? (use short phrases)

1.....

2.....

3.....

PART 6. Participant's characteristics: (tick/circle all proper indicators)

- 1. Nurse, 1=2YT<sup>1</sup>, 2=TC<sup>2</sup>, 3=UC<sup>3</sup>
- 2. Doctor, 1=resident, 2=registrar, 3=consultant
- 3. Sector, 1=surgical, 2=medical
- 4. Years, in professional practice (put number)
- 5. Gender, 1=male, 2=female

<sup>1</sup>: 2year training, <sup>2</sup>: Technological certificate, <sup>3</sup>: University certificate

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