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Original Paper

Attitudes Toward Informing the Cancer Patient—A Survey of Norwegian Physicians

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To examine Norwegian physicians' attitudes to informing patients of a diagnosis of cancer, a random sample of 1467 were surveyed. The respondents rated their level of agreement to 14 statements, and the responses were analysed by chi-squared statistics. 990 physicians responded (67%). Only 30.5% of the responding physicians had treated more than 10 cancer patients the previous year, which included 7.8% who had treated more than 50. 40.4% had treated none. The great majority (81%) preferred full information of the diagnosis. Physicians with increasing age preferred relatives not being present and gave priority to factual information and informing patients with the same diagnosis identically. Hospital physicians (39.5%) more often preferred other health professionals being present than physicians in private practice (18%) ($P < 0.001$). Number of cancer patients treated was not associated with attitudes toward the disclosure of information. Norwegian physicians prefer revealing the cancer diagnosis to patients, but have divergent opinions about how to do so. Some of these indicate suboptimal information-giving. Copyright © 1996 Elsevier Science Ltd

Key words: attitude of health personnel, communication, human, neoplasms/px (psychology), physician-patient relations, physician's role, questionnaires, truth disclosure

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INTRODUCTION

WHETHER OR NOT to inform the patient of the diagnosis has been a widely debated issue in cancer care [1]. Physicians in the United States have completely reversed their policy towards revealing the cancer diagnosis, with 90% of the physicians preferring not to inform the patient in 1961 [2] compared with 95% preferring to inform the patient in 1979 [3].

Recent international surveys indicate that physicians in Northern and Western Europe (including Norway), in contrast to their colleagues in Southern and Eastern Europe, mainly practice disclosure [4, 5]. However, data supporting disclosing the diagnosis as the predominant policy in Scandinavia [6] are limited to the aforementioned surveys.

When disclosure is the preferred policy, the physicians face the challenge of how to tell the patient. Principles of ethics, law and psychological care of the individual patient may converge to create difficult dilemmas such as: what shall be the content of the information on a disease as unpredictable

as cancer, how is the information best presented and how are the patients' reactions dealt with? Much of the public discontent with the medical profession is probably related to deficiencies in this area of clinical communication [7].

We know little about the ways in which physicians inform cancer patients of their diagnosis and how the information is perceived by the patients [1]. The literature guiding the physician on how to inform the patient is rather sparse, and the physician must rely on his own personal judgment and experience [8].

The aims of this survey were, therefore, to examine whether Norwegian physicians prefer revealing the cancer diagnosis, to explore the physicians' attitudes towards the implications of telling the patient, and to examine how this relates to the physicians' age, sex, present type of medical work, speciality and number of cancer patients treated during the last year.

MATERIALS AND METHODS

In 1993 an anonymous postal survey of Norwegian physicians' health, sickness, working and living conditions was conducted. The random sample included 9266 physicians,

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comprising 77% of all active physicians in Norway. One of the questionnaires, distributed to a random subsample of 1467 physicians, included 14 statements regarding disclosure of the cancer diagnosis. The statements were specifically designed for this study and were not pilot-tested. Demographic background variables were obtained from the main survey.

A total of 990 physicians (response rate 67%) returned the questionnaires after one written reminder. The response rate was equal among the two sexes (67%), lowest among the age group 25–29 years (63%) and highest among the age group 50–59 years (71%). The characteristics of the respondents are presented in Table 1.

In Norway most of the physicians are employed by the counties and work in hospitals (57.7% of the respondents). Physicians in private practice (16.3%) are mainly general practitioners. Physicians working in public health (15.5%) are either Public health officers or general practitioners. Most of

the physicians (69.5%) had treated less than 10 cancer patients the preceding year including 400 (40.4%) who had treated none. Among the latter, the majority were either not specialists (40%), psychiatrists (14%) or specialists in laboratory medicine (11%).

The attitudes toward informing the cancer patient were measured by asking the respondents to indicate the degree to which they agreed to 14 statements on a five-point scale ranging from strongly agree (=1) to strongly disagree (=5) with a neutral category in the middle. The statements, arranged by topic, and the distribution of the responses are listed in Table 2.

Comparisons between subgroups are based on chi-squared statistics (Pearson chi square and Mantel-Haenszel test for linear association). *P*-values equal to or less than 0.01 (adjusted for multiple comparisons) were considered significant if the criteria of WG Cochran (expected frequency > 5 in more than 80% of the cells and expected frequency in all cells > 1) were met [9]. The statistical analysis was performed by using the SPSS for Windows v 6.0 software (SPSS Inc., Illinois, U.S.A.).

Table 1. Sociodemographic and background variables among the respondents

| | | |
|---|--------------------------|-------------|
| Age (years) | Mean = 42.66 S.D. = 9.64 | |
| Age groups (%) | 25–29 | (6.1) |
| | 30–39 | (37.2) |
| | 40–49 | (33.6) |
| | 50–59 | (17.1) |
| | 60–69 | (6.1) |
| Sex (n, %) | | |
| | Female | 285 (28.8%) |
| | Male | 703 (71.2%) |
| Last speciality* (n, %) | | |
| | Not specialist | 398 (40.2%) |
| | General practice | 142 (14.4%) |
| | 'Laboratory medicine'† | 49 (5.0%) |
| | 'Internal medicine'‡ | 160 (16.2%) |
| | 'Surgery'§ | 144 (14.6%) |
| | Psychiatry | 59 (6.0%) |
| | Public health | 37 (3.7%) |
| Present type of work (n, %) | | |
| | Hospitals | 559 (57.7%) |
| | Public health | 150 (15.5%) |
| | Occupational medicine | 34 (3.5%) |
| | Private practice¶ | 158 (16.3%) |
| | Other | 67 (6.9%) |
| Number of cancer patients treated during the last year (n, %) | | |
| | None | 400 (40.4%) |
| | 1–9 | 288 (29.1%) |
| | 10–49 | 225 (22.7%) |
| | 50 or more | 77 (7.8%) |
| (Not all respondents answered all questions) | | |

* The specialities are grouped. 593 (59.9%) had one speciality, 188 (19%) had two specialities. † Includes specialists in radiology (*n* = 26), pathology (*n* = 10), medical microbiology (*n* = 7) and other non-clinical specialities. ‡ Includes internists (*n* = 68), paediatricians (*n* = 28), ophthalmologists (*n* = 17), neurologists (*n* = 10), dermatologists (*n* = 10), rheumatologists (*n* = 10), oncologists (*n* = 5) and subspecialists like endocrinologists. § Includes general surgeons (*n* = 52), anaesthesiologists (*n* = 30), gynaecologists (*n* = 29), oto-rhino-laryngologists (*n* = 21) and subspecialists like orthopaedists. || Includes both Community general practitioners and public health officers. ¶ Includes General practitioners (*n* = 63), internists (*n* = 18), surgeons (*n* = 18), psychiatrists (*n* = 12) and 50 non-specialists.

RESULTS

The response distributions are presented in Table 2.

Whether to tell

The great majority of the respondents (81%) indicated that cancer patients should receive the complete truth about their diagnosis.

Why to tell

Psychological factors were considered important to the course of cancer by 82% of the respondents. This view was more frequent among females (58% strongly agreeing) than among males (47% strongly agreeing) (*P* = 0.004 chi square = 15.93, *df* = 4). Information was judged to improve the patients' coping (91%) and to reduce psychological distress (75%).

How to tell

Fifty-six per cent felt that relatives should not be present when the diagnosis is revealed, with a linear trend for not wanting relatives present with increasing age of the physician (*P* < 0.001 chi square = 16.61, *df* = 1). Forty-one per cent did not want other health professionals present when informing about the diagnosis. Different attitudes between physicians with different types of work (*P* < 0.001 chi square 64.78, *df* = 16) and with different specialities (*P* < 0.001 chi square = 68.19, *df* = 24) were found. More of the physicians working in hospitals (39.5%) wanted other health professionals present than physicians working in private practice (18%), public health (17%) or occupational medicine (12%). More of the surgeons (44.5%) and the internists (37.5%) wanted other health professionals present than the general practitioners (13.5%).

Thirty-six per cent stated that cancer patients with the same diagnosis should be informed as identically as possible while 49% disagreed. There was a linear trend toward preferring identical information with increasing age of the physician (*P* = 0.001, chi square = 10.14, *df* = 1). Sixty per cent thought that the accurate presentation of medical facts is the main purpose when informing of a cancer diagnosis, and with

Table 2. Attitudes to information about the cancer diagnosis among Norwegian physicians (in % of total numbers = n)

| Statements | 1 | 2 | 3 | 4 | 5 | n |
|---|-----|-----|-----|-----|-----|-----|
| <i>Whether to tell</i> | | | | | | |
| Cancer patients should not receive the complete truth about their diagnosis. | 3% | 11% | 6% | 20% | 61% | 968 |
| Most of the information to patients with recently diagnosed cancer should be given by other health professionals. | <1% | 2% | 5% | 14% | 79% | 972 |
| <i>Why to tell</i> | | | | | | |
| The clinical course of cancer is minimally affected by psychological factors. | 3% | 4% | 10% | 32% | 50% | 973 |
| Thorough and immediate information improves the cancer patient's coping. | 75% | 16% | 8% | <1% | <1% | 974 |
| Information about the disease has little effect on reducing psychological distress among cancer patients. | 5% | 8% | 12% | 28% | 47% | 972 |
| <i>How to tell</i> | | | | | | |
| Information to patients with recently discovered cancer should be given in private. | 89% | 7% | 1% | 1% | 1% | 973 |
| Information on recently discovered cancer should be followed up by offering further consultations. | 95% | 4% | <1% | <1% | 1% | 975 |
| Relatives should not be present when a patient receives the cancer diagnosis unless the patient specifically asks for it. | 36% | 20% | 17% | 16% | 11% | 971 |
| Other health professionals should be present when a cancer patient is informed about the diagnosis. | 11% | 20% | 28% | 19% | 22% | 973 |
| Cancer patients with the same diagnosis should be informed as identically as possible. | 12% | 24% | 16% | 32% | 17% | 972 |
| When informing on recently discovered cancer, the main purpose is to present the medical facts accurately. | 28% | 32% | 8% | 25% | 7% | 972 |
| When a cancer patient is informed about the diagnosis, it is important to discuss the patient's emotional reactions to the information. | 71% | 22% | 6% | 1% | <1% | 974 |
| <i>Consequences of telling</i> | | | | | | |
| After having received the cancer diagnosis, the patient's first thoughts are about death. | 38% | 36% | 16% | 8% | 2% | 968 |
| Criticism from cancer patients of poor information from the doctors are mostly unjustified. | 4% | 24% | 30% | 32% | 11% | 970 |

1, Strongly agree; 2, Partly agree; 3, Uncertain; 4, Partly disagree; 5, Strongly disagree.

increasing age more of the physicians held this view ($P < 0.001$, chi square = 18.02, df = 1).

Consequences of telling

Seventy-four per cent of the respondents stated that the patients' first thoughts after having received the cancer diagnosis would be thoughts of death. More of the female physicians (48% strongly agreeing) than the males (34% strongly agreeing) held this view ($P = 0.002$, chi square = 16.97, df = 4).

Criticism from cancer patients of poor information from the physicians was considered justified by 43% of the physicians. There were different opinions of this statement between the age groups ($P = 0.006$, chi square = 33.59, df = 16) with 20% of the youngest (aged 25–29 years) sharing this view compared to 40% of those aged 50–59 years. With increasing number of cancer patients treated within the last year, more of the physicians considered criticism unjustified ($P < 0.001$, chi square = 11.47, df = 1). In addition, there were different opinions between physicians with different specialists ($P < 0.001$, chi square = 68.42, df = 24), most prominently between the surgeons (43% considering criticism unjustified) and the general practitioners (19.5% considering criticism unjustified).

DISCUSSION

Full information of the diagnosis to cancer patients is preferred by the great majority of Norwegian physicians regardless of their background. However, the Norwegian physicians display different opinions of how to inform patients of the diagnosis. Individualised information, lesser emphasis on medical facts when informing and a preference for relatives being present were more often preferred among the younger physicians. Physicians working in hospitals were more often in favour of informing with other health professionals present than those in primary care. The number of cancer patients treated during the last year was insignificant in relation to difference of attitudes. Physicians treating a larger number of cancer patients stated that the patients' criticism of poor information received from physicians was unjustified.

In contrast to previous studies on this topic, the material in this survey is both large (990 respondents) and representative of the physicians in a whole nation [10]. The response rate (67%) is considered satisfactory compared with other surveys of physicians [3, 10]. However, the high level of agreement on some items reduces the variance and thereby limits the possibility of finding differences in attitudes between subgroups. This may reflect the questionnaire not being sensitive

enough to detect more subtle attitude differences between groups. However, the high level of agreement may also reflect common perceptions and ideals within the Norwegian medical community. For example, finding that 95% strongly agree that information on recently discovered cancer should be followed up by offering further consultations may be an indicator of this. Our clinical impression is that offering follow-up consultations as standard practice when patients have been informed about a cancer diagnosis is not the rule. Attitudes are not perfect reflections of true activity, but nevertheless strong determinants of behaviour. Physicians probably overestimate both the time and quality of their information-giving [11]. Our findings should, therefore, mainly be interpreted as the physicians' perceptions of their behaviour and their preferences for their actions. The study being accomplished without pilot-testing may be another limitation of possible significance for the sensitivity and specificity of the results. However, since the study aimed at describing the physicians' attitudes and the results do not have therapeutic consequences, we feel this limitation is less relevant.

Some authors [4, 12] have pointed to the importance of understanding the practice of disclosure in a cultural context. The change of attitudes toward disclosure among physicians in the United States has been linked to improved therapeutic possibilities for several types of cancer and to social changes such as: lesser stigmatisation of cancer, new legislation, the rise of patient consumerism, changes in the physician-patient relationship, increased patient autonomy and increased public scrutiny of the medical profession [3]. Similar changes may be observed in the Norwegian society. However, other cultural traits, such as the degree to which cancer is associated with death [13], might explain why disclosure was adopted so quickly in Northern Europe compared with other parts of the world.

Psychological effects to the patient have been among the most cited reasons given by physicians for both disclosing and withholding the cancer diagnosis [14]. In both the 1961 survey [2] and the 1979 survey [3], in which the surveyed physicians held exact opposite views on disclosure, the authors concluded that the physicians' attitudes toward disclosure were grounded on personal and emotional beliefs, although the physicians perceived their attitudes to be the result of clinical experience. The positive psychological effects of disclosure is probably not only related to the information received but also to other aspects of the communication process [15], such as expressing empathy, giving the patient time to absorb the diagnosis and engaging the patient in decision-making. The extent to which the physicians attribute the effects of disclosure to the information itself or to these other aspects of the communication would, therefore, be of interest in future research.

The younger physicians, compared with the older, were more often in favour of having relatives present, putting lesser emphasis on the strict presentation of medical facts and on informing cancer patients with the same diagnosis identically. Firstly, these findings indicate emotionally supportive attitudes toward the presentation of the cancer diagnosis being more common among the younger physicians. Secondly, they might indicate on-going changes of the physicians' perceptions of the physician-patient relationship away from the paternalistic model [16] and toward a more patient-oriented model. Thirdly, they might reflect how physicians' attitudes and perceptions change with increasing age or experience.

Due to the cross-sectional nature of this study, we cannot

draw definite conclusions about whether these differences represent substantially different attitudes between cohorts of physicians. Some factors may be of importance for shaping these differences. The younger physicians have little or no experience in withholding the diagnosis, and they may thereby be more flexible in their approach to telling. They are probably more familiar with the idea of interdisciplinary work, and they might also be influenced by changes in the medical curricula over the last 10 years, with a greater emphasis on the physician-patient relationship.

Our findings of older physicians more often preferring distancing ways of informing by giving priority to identical information to patients with the same diagnosis and emphasising the factual medical information may reflect these physicians being educated at a time with lesser emphasis on patient communication. Taylor observed how physicians' techniques of disclosure were geared toward reducing physician, not patient anxiety [17], and one may question if these distancing attitudes reflect the physicians' adaptations to the discomfort and difficulties in communication older physicians are reported to experience facing dying patients or cancer patients [18, 19]. This seems to be of special clinical interest, given the importance patients probably attribute to other aspects of the communication about the diagnosis than the pure presentation of factual information [15].

The different attitudes held by "sole-practitioners" and hospital physicians toward other health personnel being present when the diagnosis is revealed, may reflect the multidisciplinary aspect of hospital medicine and the availability to other health professionals. Due to technological advances, it will increasingly become the primary care physicians' duty to tell the patient the cancer diagnosis [20]. Other health personnel have been found important as providers of emotional support to cancer patients [21]. Our findings therefore point to the importance of the conceptual framework within which practitioners operate for the care they provide, and to possible improvements in cancer care.

Physicians treating patients with other diseases than cancer also break bad news by informing patients of conditions likely to alter their future drastically [22]. Similar attitudes found among physicians treating many or no cancer patients may reflect this and also general beliefs in a society at a given time. However, treating a greater number of cancer patients was associated with considering criticism of poor information from physician to the cancer patient unjustified. Those physicians treating a large number of cancer patients may consider criticism unjustified because they believe their communication skills are good as a result of their experience. However, the proportion of cancer patients dissatisfied with physicians' communication has remained relatively constant over the last 25 years [23], and, in one study, 50% of patients with breast cancer involved in treatment trials stated that information had been inadequate [24]. One may postulate if these physicians, treating many cancer patients, employ defensive strategies by judging criticism as unjustified. As pointed out by Buckman [22], communicating with cancer patients confronts the physicians to his/her anxieties and fears.

Disclosure is viewed as the "gold-standard" within the Norwegian medical community, but physicians' attitudes toward implications of such a policy are divergent. Some of these attitudes may be indicative of suboptimal information giving. More studies are needed to assess the effects of various physicians' attitudes on patients' responses. Whether phys-

icians attribute the positive effects of disclosure to revealing information itself or to other aspects of the communication process seems of special clinical relevance as do the extent to which they perceive information giving as factual, emotional supportive or both.

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