



Identifying Appropriate Methods of Diagnosis Disclosure and Physician-Patient Communication Pattern among Cancer Patients in Iranian Society

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Abstract

Cancer is one of the diseases which make people worry about it all the time. Most people know cancer in terms of death. Training cancer patients about their disease is a part of their treatment. They need training and support in order to cope with disease symptoms and treatment. There is no comprehensive information about awareness rate of Iranian cancer patients from their disease that they prefer to receive necessary information through which person and in which time. Present research is in a field method and has been conducted based on focus group interviews with 40 male cancer patients informed of their diagnosis. Sampling method was available sampling. Statistical universe included all patients referring to blood and oncology center of Dr. Shariati Hospital in Tehran. According to findings, specialist physician is the most suitable person for diagnosis disclosure and breaking bad news. Appropriate time is the interval between definitive diagnosis and initial treatment. Patient prefers to be alone while hearing cancer diagnosis. Also, specialist physician discloses disease diagnosis personally with him in an interval between definitive diagnosis and initial treatment. Cancer Patients prefer active-passive communication pattern which might be caused by dominant culture on Iranian Society ($p < 0.01$). In Iran people believe that if patients were aware of their disease, perhaps they may be lost sooner. The amount and accuracy of information disclosure in different countries are different.

Keywords: Cancer, diagnosis disclosure, pattern, physician- patient.

Introduction

Today, cancer is the cause of 12% of mortality entire the world. In Iran, more than 30,000 persons pass away annually due to cancer and it is estimated that more than 70,000 new cancer subjects occur in the country. Scientific secretary of the Iranian Surgeons Society addresses that, based on conducted assessments; proportion of cancer in women under 30 years old in Iran is double the proportion in other countries. Three categories of factors can effect on patients' adaptation with cancer which include factors concerned with society, patient and cancer. In the factors concerned with society, role of breaking bad news way to patient about diagnosis, knowledge of patients about treatment options, prognosis and active participation in treatment are emphasized¹. The cancer diagnosis disclosure through an open discussion, employing the term "cancer", providing required information for the patient, answering to patients' questions, opening emotions of the patient and realistic ensuring the patient are of the factors effective on psychological adaptation and patient's satisfaction while breaking such bad news. In addition, discussion about prognosis and treatment options is effective to reduce psychological distress and increase patients' satisfaction^{2,3}. Primarily, there are three communication patterns between physician and patient as

follows: First, Active- Passive pattern: it occurs when the patient is not able to participate in healthcare and making decision about himself/ herself due to specific conditions of the disease. Second, Guidance- Cooperation pattern: it occurs when the physician is in charge of a major part of diagnosis and treatment. Third Mutual participation pattern: it needs common deciding of physician and patient about all aspects of disease care. This pattern is the most perfect possible treatment interaction between patient and physician⁴. There is no available information about communication pattern between physician and cancer patient and we do not know which pattern is preferred by patients with cancer while passing treatment procedures. This issue can be affected by culture of Iranian society. Cancer diagnosis has severe psychological consequences for patients and their families. A study in Japan where eastern culture is governed shows that prevalence of mental disorders in non-informed patients of cancer diagnosis is lower than informed patients⁵. In contrast, an assessment on the relation between information on cancer and psychiatric disorders among the patients with advanced cancer in Britain suggests that information on cancer itself does not lead to depression and desire and knowledge to be aware of the diagnosis is of psychological distress independent⁶.

Mitchell also reviewed and documented differences between cultures in terms of diagnosis disclosure. This study addresses that medical information disclosure is conventional in such countries as Australia and Eastern Europe so that physicians take a value for frank dialogue about cancer diagnosis and this is while lack of disclosure is conventional in some Eastern and Southern Europe countries⁷. In the US, up to 97% of physicians believe that disease diagnosis should be disclosed to the patients with cancer⁸. In a study conducted in Scotland, physicians suppose that only 42.2% of their patients who were died due to cancer were also quite informed of their diagnosis⁹. In an assessment performed on 219 physicians, 90% mentioned that they usually do not disclose cancer diagnosis. In another research where 5000 physicians were asked about this issue, 23% mentioned that they never tell the patient about the cancer diagnosis, although such physicians declare that if they themselves be infected with a hard disease, they like to be informed⁸. So, it seems that cultural values play determinant role and we can not only rely on research findings to make decision in a society¹⁰. A high percent of informed patients obtain their information indirectly. Essentially, patients' reports regarding awareness of the diagnosis and prognosis are not always due to verbal information of physicians and it is cleared that patients with cancer obtain most of their information due to their previous experiences of cancer, non-verbal behavior in family as well as mass media and other information resources¹¹. To assess the question that whether diagnosis and prognosis of cancer should be disclosed to the patients with cancer at final stages of disease or not, an interview was done with 119 physicians. A total of 53 physicians (44.5%) had no patient passed away recently due to cancer. 56 physicians (84%) and 62 physicians (93.6%) did not address diagnosis and prognosis, respectively, to the patients with cancer who have been passed away recently, while 65.5% of physicians believed that always and 7.6% believed sometimes diagnosis and prognosis should be disclosed to patient. Estimated social class by the physician was related with awareness of diagnosis and prognosis. The main reason to not breaking bad news for patient was physician's fear of anxiety and distress and emotional reactions of patients⁸. Montazeri conducted a study in Imam Khomeini Hospital aimed to assess Quality of Life (QOL) in patients with cancer where QOL of 142 patients was assessed through QLQ questionnaire. 48% of patients were informed of cancer diagnosis and 52% were not. Results were analyzed by independent T-test ($P < 0.001$) which suggest that non-informed patients have better emotional, physical and social QOL than informed patients. As Montazeri believes it seems that in addition to cultural differences, the way how patients are informed of cancer diagnosis plays an important role to increase or decrease psychological distress and Quality of Life. A descriptive-comparative study was done by Azad Rahmani in educational-treatment center of Shahid Ghazi Tabatabaei in Tabriz, Iran. Research sample included 150 patients informed of their definitive cancer diagnosis and 150 patients were non-informed of. By using Heart Hope Index inventory, it cleared that hope between the informed patients was 37.61 ± 6.42 while

it was 37.16 ± 7.10 for non-informed ones which shows no significant difference ($P = 0.57$). These results can reveal that being aware of cancer diagnosis has no impact on patients' hope level. The statistics show that more than 60% of patients with different cancers can get relative improvement using usual and conventional treatments and have a relatively good longevity; but in some cultures, a patient with cancer is confronted with behaviors which induct absolute and certain death on the patient. In fact, there has been still no precise information about the difference to disclose such information between developed and developing countries and relative role of cultural and personal factors of patients and physicians in this regard has not been cleared yet. Actually, there is no information in line with patients' willingness about diagnosis disclosure and prognosis in Iran, too. Clinical facts imply that the patients who have received information suitably can better get compatible with their status. Present study tries to evaluate level of awareness among Iranian patients and their views about the breaking bad news way and their information needs. On the other hand, how to deal with cancer has a major relation with kind of family and social willingness of people towards this disease. Researchers and specialists often refer in seminars to the note that formed cultures and micro-cultures regarding cancer and wrong way of dealing with patient and disease how can make duty of doctor, advisor and the patient himself harder. Also, a question addressed about a patient with cancer is that whether these patients need to social support of their friends and relatives. Therefore, research necessity in this regard gets clearer and yielded data can be used only on studied country and the results cannot be generalized to other countries with different cultures.

Material and Methods

This research was conducted in field method based on group interviews concentrated on male patients with cancer having 20 to 40 years old. Sampling method was available sampling. Statistical universe included all patients referring to blood and oncology center of Dr. Shariati Hospital in Tehran to do chemotherapy who were informed of their disease diagnosis. A total of 40 people were participated in the study after offering some descriptions about investigation and getting satisfied. Among members of sample group, there exist single and married people with educations from sub-diploma to Master of Science and occupations from retired or disabled to self-occupation or being in military service period. These people were attended in five groups of 8 persons and interview was done based on questions' guide (content of these questions were validated based on studying books, journals and ideas of some specialists). The members in these groups were encouraged to announce their ideas about the discussion subject (i.e. identifying appropriate methods to inform the patients with cancer about their disease). Ethical considerations in present study are awareness of research objective, voluntary participation in the test and confidentiality of the subject's characteristics and information. For this purpose, a written agreement to participate in the research was obtained from

subjects and they could cancel to continue cooperation on the study whenever they wanted. Finally SPSS tool was employed to analyze data.

Results and Discussion

In order to assess and respond to questions of this research, initially data was coded and input in computer through content

evaluation. Reports yielded were analyzed using proper statistical methods (e.g. chi-square test). Results were assessed with null hypothesis of data distribution in different issues in which, according to significance level ($P < 0.01$), the difference between different issues of these variable is statistically significant. About demographical data, sample group members are often from moderate social class.

Table-1
Descriptive information regarding the patient's willingness to diagnosis disclosure

		Quantity	Percent
Willingness to diagnosis disclosure	Positive	32	80
	Negative	8	20
	Total	40	
The time being informed of diagnosis	After definitive diagnosis	11	27.5
	Before treatment commencing	13	32.5
	Middle of treatment period	11	27.5
	Within the disease recurrence period	5	12.5
	Total	40	

Descriptive information regarding the patient's willingness to disclose the diagnosis reveals that 80% of sample group members were willing to be informed of their diagnosis, while only 27% were informed after definitive diagnosis.

Table-2
Descriptive information of informer person, conditions and place of diagnosis disclosure

		Conditions of diagnosis disclosure							
		Individually and Solely			In presence of family members or relatives			Total	
		Qty	% in row	% in column	Qty	% in row	% in column	Qty	% in column
Informer	Specialist physician	4	36.4	30.8	7	63.6	38.9	11	35.5
	A member of family	2	22.2	15.4	7	77.8	38.9	9	29.0
	A member of medical team	1	50.0	7.7	1	50.0	5.6	2	6.5
	Randomly or indirectly	6	66.7	46.2	3	33.3	16.7	9	29.0
	Total	13	41.9	100.0	18	58.1	100.0	31	100.0
Place	Physician's office	2	40.0	18.2	3	60.0	16.7	5	17.2
	Infirmery/ Hospital	6	46.2	54.5	7	53.8	38.9	13	44.8
	Home/ non-therapeutic environment	3	27.3	27.3	8	72.7	44.4	11	37.9
	Total	11	37.9		18	62.1		29	

An abundance of 50% exists among sample group members who were informed of the diagnosis indirectly or through persons other than the physician. Descriptive information was analyzed in terms of informer person, conditions and the place where patient is informed from his/her disease.

Table-3
Descriptive information in terms of seeking for social support

		Seeking for social support							
		Seeking for social support			Isolation and withdrawal			Total	
		Qty	% in row	% in column	Qty	% in row	% in column	Qty	% in column
Sympathetic person	Spouse, parents, or family members	10	62.5	62.5	6	37.5	46.2	16	55.2
	Friends and relatives	4	100.0	25.0	0	.0	.0	4	13.8
	No body	0	.0	.0	5	100.0	38.5	5	17.2
	Medical team members	2	50.0	12.5	2	50.0	15.4	4	13.8
	Total	16	55.2		13	44.8		29	

In present study, number of individuals having willingness towards isolation and withdrawal is high, despite having a sympathetic person (members of family or treatment crew). This abundance is about 40%. Descriptive information in terms of seeking social support and a sympathetic person proves this issue.

Table-4
Information kind which the patient prefers to know

		Qty	Percent
Need to information	Disease and its course	1	2.6
	Methods of treatment and their complications	8	20.5
	Prognosis about individual cases	5	12.8
	All before mentioned cases	17	43.6
	Lack of willingness to provide information	8	20.5
	Total	39	100.0

In terms of the information kind which the patient prefers to know, about 50% of patients like to be quite informed of their disease, prognosis and treatment methods.

Table-5
Communication pattern between patient and physician

		Present pattern											
		No specific pattern	Active- Passive pattern		Active- Passive pattern			Active- Passive pattern			Total		
		Qty	Qty	% in row	% in column	Qty	% in row	% in column	Qty	% in row	% in column	Qty	% in column
Disadvantages	No specific disadvantage	0	14	73.7	45.2	4	21.1	50.0	1	5.3	100.0	19	47.5
	Active- Passive pattern	0	17	81.0	54.8	4	19.0	50.0	0	.0	.0	21	52.5
	Guidance- cooperation pattern	0	0	.0	.0	0	.0	.0	0	.0	.0	0	.0
	Mutual participation	0	0	.0	.0	0	.0	.0	0	.0	.0	0	.0
	Total	0	31	77.5	100.0	8	20.0	100.0	1	2.5	100.0	40	100.0
Advantages	No specific advantage	0	2	100.0	6.5	0	.0	.0	0	.0	.0	2	5.0
	Active- Passive pattern	0	13	92.9	41.9	1	7.1	12.5	0	.0	.0	14	35.0
	Guidance- cooperation pattern	0	15	71.4	48.4	6	28.6	75.0	0	.0	.0	21	52.5
	Mutual participation	0	1	33.3	3.2	1	33.3	12.5	1	33.3	100.0	3	7.5
	Total	0	31	77.5		8	20.0		1	2.5		40	

Based on present study's finding, the Active-Passive pattern is dominant communication pattern between patient and physician. More than 50% of patients prefer this relationship, as well. Most of patients declared no specific advantage or disadvantage for this pattern. What declared from patients about advantages and disadvantages shows that patients suppose that disadvantages are caused by physician's disability or individual little attention, while in contrast, suppose that advantages are caused by physician's interactive pattern and modus operandi.

Patients with cancer typically experience a range of symptoms including pain and variety of physical and psychological discomforts and immediately after the disease diagnosis, anxiety and other mood disorders may be formed in person where these symptoms vary over time and in response to diagnosis, recurrence and prognosis¹². Given this general belief that bad news (e.g. about poor prognosis of disease) results in psychological distress, sadness and anxiety¹³. Hence, families ask the physician to hide medical information and cancer diagnosis in order to protect the patient¹⁴. In terms of cancer diagnosis disclosure, lots of cultural groups believe that open and frank discussion about the diagnosis and prognosis of cancer is inhumane and cruel and it is not necessary to avoid it; and this is while in some cultural groups, hiding medical information from the patient is irrational and immoral¹⁵. Breaking bad news by physicians to patients with cancer is somewhat under debate specifically about diagnosis and prognosis. Most of people would like to know that if they are in last stages of disease or not¹⁶. However, 40% of patients do not like to know any details about this issue^{17,18}. Generally, it is generally agreed that patients have the right to have enough information about their disease, though still lots of physicians believe that it is not rational to breaking such bad news that the patients are passing away. The amount and accuracy of information disclosure in different countries are different. In Iran, cancer means death which is hidden by people from each other and they believe that if patients were aware of their disease, perhaps they may be lost sooner. The families always ask from employees to not disclose the disease kind to their patients. From previous researches in Iranian society, different results are yielded in terms of awareness of cancer patients of their disease kind and the reaction they show which absolutely such findings are related to Iranian society and will not be the case for other countries. As before mentioned, previous results were as follows: Tabatabaei (1993) showed while a high number of patients were not informed of diagnosis and prognosis, they were passed away due to cancer. Ali Montazeri also reveals that QOL of patients non-informed of diagnosis is much better than informed ones. This is while Azad Rahmani addresses that the life expectancy does not matter among informed and non-informed patients of their disease. Ultimately, results of present study suggest that: 80% of the sample group members were willing to be informed of their diagnosis while only 27% of them made aware of their diagnosis after definitive diagnosis. Failure to meet expectations and performance of health staff in this regard is substantial. Also, it can be

concluded that overall cultural perspective on cancer patients and how to interact with them (which is based on to avoid providing information in order to prevent harm to such people) is common in mental space of health staff and patients' family, more than having real and concrete areas. Regarding the informer person and social conditions of diagnosis presenting and given the existing attempts based on presence of relatives to support patients and physicians' active role in this regard and its comparison with patients' perspective which suggests private situation preference between patient and physician, we see another gap between expectations and existing performance in this regard which is considerable. In this regard, it can be concluded that physicians themselves need to have social support and in such cases, family and relatives prioritize on willingness and preference of patients.

Based on patients' attitudes in sample population, specialist physician is the most suitable person to disclose cancer diagnosis and thereby breaking bad news. In terms of disclosure place, no difference was observed. However, about disclosure time, patients prefer to be informed of their disease in the interval between definitive diagnosis and initial treatment. Also, in terms of presence or absence of other people while disclosing the diagnosis, "solely and personally" is the preferred condition. Although in comparison with other measured issues, research individual differences are more seen in the case of present research. Active- Passive pattern is preferred by patients as physician and patient communication pattern- i.e. cancer patients often are willing to be supported by their physician and they do not like to have any opinions.

Of course, attitude to this subject in the different times and diverse cultures is varying. Cancer is considered as one of the scariest diseases among cultures and is not innocent from cultural factors impact like other diseases. Cultural aspects, values and behaviors along with life experiences, social-economic status and personality differences determine cancer meaning for patients and their families and effects on the way they overcome the disease¹⁷.

Conclusion

Research evidences show that lots of the patients with cancer in Iran are not well informed about diagnosis and prognosis of their disease, while their families are aware and they prevent to disclose cancer diagnosis in order to avoid the creation of tension and distress in their patients. Also, most of Iranian physicians avoid breaking bad news for cancer patients¹⁸. But, physicians generally should consider individual characteristics of patients and their perception level¹⁹. Finally, it is proposed that, in order to improve Quality Of Life of such patients, an assessment be conducted with an experimental approach on the role of psychological training and empowering cancer patients, their families as well as physicians and health staff, and if possible, required trainings be provided for these groups.

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