Introduction: Although most patients wish to be fully informed about bad news such as a diagnosis of cancer, a significant minority prefer no or minimal information. We examined the value of asking patients about their disclosure preferences at the outset of hospitalization.

Methods: Consecutive patients admitted to a respiratory and a geriatric unit were asked whether and how they would wish to be told of cancer or Alzheimer disease.

Results: Of the 207 patients interviewed, 174 (84%) wanted to be told about cancer or dementia; the proportion who would wish to be told did not differ between older patients (89 of 108 patients; 82%; p = 0.34) and younger patients (85 of 99 patients; 86%; p = 0.34). Thirty patients (15%) sought reassurance during or after the interview, and 13 patients (6%) reported that they had been bothered by the questions. Of the 207 patients, cancer or dementia was diagnosed in 23 patients (11%). Preferences for disclosure or nondisclosure were honored for 20 patients (87%).

Conclusions: Seeking preferences regarding truth disclosure at the outset of hospitalization is helpful and feasible in everyday practice, and the results can be used by clinicians to improve communication with patients and families in accordance with patients’ own wishes.

Key words: cancer; ethics; older people; truth disclosure
sure might help physicians to satisfy the information needs of individual patients. This is analogous to the use of advance directives to determine patient preferences regarding end-of-life-care. This study examines the feasibility of this approach in clinical practice.

**Materials and Methods**

Consecutive, English-speaking patients who were admitted to the respiratory and geriatric medical units of a 730-bed university teaching hospital over a 3-month period were considered for the study. These units share an acute general medical on-call day (1 in 6 days for the whole hospital) as well as pursue their specialty interests. We excluded patients who had been admitted for the treatment of previously diagnosed cancer and those who did not wish to participate or could not be interviewed because of severe cognitive disturbance or major communication difficulties, or because they were too ill. The study was approved by the local ethics committee. It was agreed that individual informed consent to participate was not required.

Patients were interviewed by one of two interviewers (DK or KN) according to a standard protocol shortly after hospital admission. It was emphasized that the questions did not imply that any individual was at particular risk of receiving bad news. We told patients that we would record and respect their preferences and that they could modify those preferences at any stage.

Subjects were asked whether they would wish to be told if a serious condition such as cancer or Alzheimer disease were to be diagnosed. Those who did not wish to be told were asked whether they would agree to be told if the doctors thought that disclosure was essential in order to discuss treatment options. Patients who wished to be told were asked whether they would wish to receive full information about prognosis and treatment, how they would like to be told, and how they would like their family to be told. Patients’ preferences were recorded in the medical notes and were communicated to medical and nursing staff dealing with the patient. Any distress or need for reassurance occurring during the interview or reported later by staff or relatives was recorded.

We examined whether preferences for disclosure differed between patients < 70 years of age and those patients ≥ 70 years of age. Patients were observed throughout their hospital stay and, if applicable, until their first post-hospital admission clinic appointment. For those patients receiving a diagnosis of cancer or dementia, we examined whether their wishes regarding disclosure were followed.

**Results**

Of 345 patients admitted to the hospital during the study period, 44 (13%) were not assessed because an interviewer was unavailable or because of rapid hospital discharge or death. Of the remaining 301 patients, 94 (31%) were excluded because of one or more of the following conditions: previous diagnosis of cancer (54 patients); cognitive impairment (14 patients); severe illness (12 patients); deafness/aphasia (9 patients); or refusal (11 patients). Of the 207 remaining patients, all were white, 109 (53%) were male, 108 (52%) were ≥ 70 years of age, 43 (21%) had been admitted to the hospital for investigation of possible cancer (37 patients) or dementia (6 patients), and the mean age was 63 years (SD, 7 years).

Of these 207 patients, 174 (84%) wanted to be told about cancer or dementia, 24 (12%) did not, and 9 (4%) were unsure. Of the 33 patients who were unsure or did not want to be told, 27 (82%) would accept being told the diagnosis if the doctors thought that it was essential to treatment. The proportion of patients who would wish to be told the diagnosis did not differ between older patients (89 of 108 patients; 82%) and younger patients (85 of 99 patients; 86%; Yates-corrected $\chi^2 = 0.92; p = 0.34$). There was no difference in the proportion of patients who stated that they would wish to be told of their condition recorded by the two interviewers (110 of 128 patients [86%] and 64 of 79 patients [81%]; Yates-corrected $\chi^2 = 0.56, p = 0.46$).

Of the 174 patients who wanted to be told their diagnosis, 140 (80.1%) wanted to be given full details of their condition. One hundred patients (57%) wanted to be given any bad news on their own, while 70 patients (40%) wanted a family member present and 4 patients (2%) wanted to be told by their family. Thirty patients (15%) sought reassurance during or after the interview. Thirteen patients (6%) reported that they had been bothered by the questions, one of whom became very tearful.

Of the 207 patients, 23 (11%) received diagnoses of cancer (18 patients [lung cancer in 16 patients]) or dementia (5 patients). Preferences for disclosure (16 patients) or nondisclosure (4 patients) were honored for 20 patients (87%). Two patients who had asked to be told and one patient who had asked not to be told later changed their minds and their revised wishes were adhered to.

**Discussion**

This study confirms the results of previous studies on truth disclosure in a more realistic clinical setting. The patients in the current study did not have a previous diagnosis of cancer and were facing the real uncertainties of hospital admission and investigation; they were aware that their preferences would be recorded and acted on if necessary. The vast majority of patients in this study wanted to be told of a serious diagnosis and most wanted full details of their condition. Somewhat surprisingly, a clear majority of patients preferred to be alone rather than with their family when told of bad news. This is contrary to the findings of other workers. Subsequently, doctors were able to comply with patients’ wishes in almost all cases.

Individual people have specific informational needs that can only be identified by asking the
individual. Respecting patient autonomy means that we should attempt to identify those who would prefer less information rather than adopting a policy of full automatic disclosure.11 This is consistent with the wishes expressed by patients in other studies.12 However, it is important that the desire to protect such patients should not lead to a lack of candor with the majority of patients who do want to know about their diagnosis. This study confirms that seeking preferences regarding truth disclosure at the outset of hospitalization is helpful and feasible in everyday practice and that the results can be used by clinicians to improve communication with patients and families in accordance with patients’ own wishes. Discussions about treatment options may mandate the disclosure of the diagnosis in some cases, and it could be argued that it is inappropriate to offer such patients the option of not receiving information. However, most of the patients who would prefer not to know of a serious condition would accept being told if that were required to provide effective treatment.

Relatives often ask that a serious diagnosis be withheld from older people,3,5 and physicians sometimes collude with them in maintaining secrecy.13 However, several reports3,14 have shown that agreement between the preferences of relatives and those of patients regarding truth disclosure was not significantly greater than that expected by chance alone. For example, we have found that three quarters of patients who are at higher risk for receiving bad news. However, most of the patients who would prefer not to know of a serious condition would accept being told if that were required to provide effective treatment.

The major disadvantage of our approach was that it led to anxiety in a minority of patients, many of whom were inevitably at low risk for receiving bad news. However, major distress was rare, and informal feedback from patients and staff was overwhelmingly positive. Hence, we believe the advantages of disclosure outweigh any drawbacks. Targeting patients who are at higher risk for receiving bad news for discussions regarding disclosure preferences could be considered, although unexpected diagnoses of cancer are not uncommon in hospital practice.

This study was conducted in a relatively monocultural society. Cultural factors strongly influence attitudes toward truth telling.6,7,10,15 For example, ethnicity was the main factor related to attitudes toward truth telling and decision making in a survey of elderly patients in North America.7 Korean Americans and Mexican Americans were significantly less likely than European Americans and black Americans to believe that patients should be told of a diagnosis of metastatic malignancy. The advance directive approach to truth disclosure warrants further assessment in other settings.

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