**NURSING STUDENT'S experenice on truthful disclosure of information to cancer patients**

Assist. Prof. Dr. Hanaa Hashem and Dr. Lamia Ismail

Ass. Prof. Medical-Surgical Nursing; Lecturer- Medical Surgical Nursing, Faculty of Nursing, CairoUniversity

Email: [dr.hanaa67@yahoo.com](mailto:dr.hanaa67@yahoo.com)

**Abstract**

**Background:** Disclosure of information to cancer patients is an area that medical professionals often find difficult. In some cases there has been conflict with whether medical professionals should inform their patients or not. Recognizing the information needs throughout the illness and manner of disclosure are pivotal in providing responsive and high-quality care. Therefore, the aim of this study was to explore nursing student's experience and view on truthful disclosure of information about diagnosis and prognosis to cancer patients. **Methods:** Eight senior nursing students were selected purposefully to participate in a qualitative, descriptive and contextual study. Data were collected by mean of individual interviews. Data analyzed using the Tesch descriptive analysis method. **Results:** Nursing students thought that the truth should be delivered gradually during stages of therapy based on patient’s psychological state. All of the nursing students consider truth telling as a patient right to take the total control of decision making process for their treatment. Majority of students see the nurses or close family members as a person responsible to break the diagnostic disclosure. **Conclusions:** Many nursing students found these interactions stressful. In the absence of much effective training nursing students may adopt inappropriate ways of delivering bad news and coping with the emotional fall-out. Recognition of these difficulties has led to many initiatives.

**Key words:** Nursing students’ experience, truthful disclosure, cancer patients, qualitative research

**Introduction:**

Cancer is a complicated illness, which for many years and in many cultures was perceived as incurable. Cancer meant death, and there was a tendency to hide the diagnosis from the patient, who was subconsciously excluded from life (Rahman, Mahmud & Mohamed, 2010 and Öksüzoglu, Abali, Bakar, Yıldırım & Zengin , 2006). Prior to the early 1980s, the practice of concealing the diagnosis of cancer and its prognosis was prevalent in medicine as physicians deemed it unethical to reveal what they considered a ‘‘death sentence’’ and patients were also reluctant to know their true condition (Kazdaglis, Arnaoutoglou, Karypidis, Memekidou, Spanos and Papadopoulos, 2010). This situation has changed: currently health professionals generally prefer to inform cancer patients about their illness. In addition, globalisation of information through the media and internet makes withholding the information from patients very difficult (Perera, Tennakoon, Kumarasiri, Jayasinghe, Rathnayake & Rajapaksha , 2013, Beyraghi, Mottaghipour, Mehraban, Eslamian & Esfahani, 2011 and Al-Amri, 2010; Shahidi, Taghizadeh-Kermani, Yahyazadeh, Khodabakhshi, & Mortazavi, 2007).

The practice of medicine is refocusing from the traditional paternalistic model, in which patient involvement is limited to giving or refusing consent to treatment, to a partnership approach, in which the process of shared decision-making requires full information on all the possible outcomes associated with each treatment option (Sarafis, Tsounis, Malliarou & Lahana, 2014, Innes & Payne, 2009 and Costantini, Morasso, Montella, Borgia, Cecioni, Beccaro, Sguazzotti & Bruzzi, 2006). Similar paternalistic practices are observed in Arab and Islamic cultures. In a survey in Turkey a significant proportion of cancer patients (44%) did not know their diagnosis. In Lebanon, where legislation allows non-disclosure, nearly half of physicians would usually tell the patient about cancer. The great majority of physicians (79%) in Kuwait would withhold the truth if the patient’s family requested them to do so, and in Saudi Arabia 75% of physicians preferred to discuss information with close relatives rather than patients themselves, even when the latter were mentally competent. In Pakistan, the age-old practice of informing the patient's family or head of the family is usually followed (Jawaid, Qamar, Masood and Jawaid, 2010).

Not disclosing the truth to patients about their diagnosis and prognosis can to some extent be justified in underdeveloped countries; where the quality of health care provided is often poor and lacking in palliative care facilities, patients with terminal cancer face the prospect of dying in discomfort and pain. In countries with more-advanced health systems, patients with terminal cancer can be reassured that everything possible will be done for them and that they will die eventually with dignity and without pain **(**Beyraghi, Mottaghipour, Mehraban, Eslamian & Esfahani, 2011, and Al-Amri , 2010).

Medical advances enable early cancer detection and a wider variety of treatment choices; thus disclosure of cancer diagnosis is no longer perceived as a death sentence. Surveys have shown a steady increase for preferred disclosure of cancer diagnosis, and a recent survey revealed that 80.7% of the general public preferred to be told of their cancer diagnosis. In contrast to the increase in the diagnostic disclosure rate, the disclosure of prognosis involving information about patients’ survival remains low. The disparity between the rates of diagnostic and prognostic disclosure may be due to doctors’ reluctance to take responsibility for the potential risks, such as shock and depression, but this does not mean that doctors believe that patients should be kept ignorant (Perera, Tennakoon, Kumarasiri, Jayasinghe, Rathnayake & Rajapaksha , 2013 and Sato, Beppu, Iba, & Sawada, 2012).

Another purpose of information giving is to reduce uncertainty and to provide a basis for action. It enables patients to make informed choices about their own health care and plan for their future. It prevents harm, as patients who are not informed about their situation may fail to get the medical support that they need (Kazdaglis, Arnaoutoglou, Karypidis, Memekidou, Spanos and Papadopoulos, 2010). Better knowledge affects patient and family responses in different clinical situations, engaging patients in their care and securing their collaboration, leading to patients’ adherence to the therapeutic or palliative schemes. Uncertainty, doubt or misinterpretation do not offer a foundation for proper psychological support (Innes and Payne, 2009).

On the other hand, when disclosing the truth, there is always the risk of shattering a patient’s hopes and dreams. Hope seems to an essential mechanism for coping with cancer and it can be jeopardized by excessive knowledge and detail. Revealing the stark reality of a cancer diagnosis is often perceived as the passing of a death sentence by the members of the health care team and this may also be the case for patients and their relatives. One the most common concerns of health care professionals is whether they are justified if harm results from telling the truth (Sarafis, Tsounis, Malliarou & Lahana, 2014).

Breaking bad news is not a common practice for nurses, with the exception of nurses in the United Kingdom (UK). Many nurses believe that their role in communicating with patients is secondary to the physician’s role. This is probably an easy way of disclaiming responsibility for a task that clearly no health professional wishes to do (Kazdaglis, Arnaoutoglou, Karypidis, Memekidou, Spanos and Papadopoulos, 2010). So, the aim of this study was to explore nursing student's experience and view on truthful disclosure of information about diagnosis and prognosis to cancer patients.

**Significance of the study:** Cancer is a major health threat with respect to morbidity and mortality rate in the world. Every year cancer rates increase by 2%, 10 million people worldwide are diagnosed with cancer and every year cancer is responsible for the death of nearly 6 million people worldwide. Despite remarkable advances in cancer treatment, it remains the most terrifying disease among critical diseases. Most people describe it as; death, pain or disorder. Some cancer patients are worried about the negative image of the public, such as bias and they are also concerned about encountering negative reactions (Oksel, Ertem & Dönmez, 2010 and Fadıloglu & Yıldırım, 2006). Disclosure to cancer patient is important in helping them to adjust, participate in decision-making in their treatment options in an age appropriate manner, and to access and receive appropriate support.

However, one of the most difficult issues facing healthcare professionals is telling cancer patients about their diagnosis and prognosis. Despite general agreement about the benefits of open communication between professionals and patients, there is still strong reluctance against disclosure of cancer diagnosis and prognosis in many cultures, particularly in Asian, Middle- Eastern and Mediterranean regions (Sato, Beppu, Iba & Sawada, 2012; Matlakala & Mokoena, 2011). If bad news is communicated badly it can cause confusion, long lasting distress, and resentment; if done well, it can assist understanding, acceptance, and adjustment. A successful relationship between patients and health care providers depends on the establishment of trust, which is strongly connected with truthful communication (Sarafis, Tsounis, Malliarou & Lahana, 2014 and Tsoussis, Papadogiorgaki, Markodimitraki, Delibaltadakis, Strevinas, Psyllakis, Tabakaki, Drossitis, Kabourakis, Papadimitraki, Krypotos, Daskalakis, Fragiadaki, Zoumadaki & Apostolakis, 2013).

The importance of nurses’ proactive role in disclosure needs to be emphasized to support caregivers in the disclosure process. One of the aims of this study hoped that the result of the study will provide nurses with a base line data to be utilized as a guide in how to do the task more effectively to produce benefits for them as well as their patients. It is also hoped that this research will pave the way for future research collaboration between nurses and other health providers i.e. physicians, psychologist and counselor for better informational disclosure.

**Definition of Concepts:** It is important to clarify key concepts used in this study, in the sense in which they are understood and used in the argument.

**Disclosure:** Disclosure is the act of disclosing, uncovering or revealing; bringing to light; exposure (Webster Dictionary,online) (Woldemariam, 2012). For this study, the term will be considered as the act of disclosing to cancer patients status, and will entail full disclosure with the patient knowing not only that they are just sick but also the actual name of the disease.

**Senior nursing students:** Senior nursing student's is defined as those who had clinical exposure with cancer patient during their study of medical-surgical; oncology and / or critical care nursing.

**Aim:**To explore nursing student's experience and view on truthful disclosure of information about diagnosis and prognosis to cancer patients.

**Subjects and Methods**

**Design:**A qualitative, phenomenological design was used in the study to capture nursing student's experience of communicating with cancer patients and how they viewed truthful disclosure of information about diagnosis and prognosis to cancer patients. The qualitative approach was chosen in order to explore the depth and complexity inherent in disclosure of information as a phenomenon because it allows the exploration of previously unforeseen lines of inquiry (Sheldon, 1998 and Strauss & Corbin, 1998). It can help examine nursing student's experience and can address questions that quantitative methods cannot. Furthermore, quantitative research tests hypotheses use traditional deductive processes to answer questions. Alternatively, qualitative research, using a systematic and rigorous inductive approach, explores nursing student's experience, why certain attitudes, beliefs, or customs developed or adopted. As such, qualitative inquiry provides a rich interpretation of nursing student's perspectives, experiences, and roles (Cohen, Kahn & Steeves, 2000; Giacomini & Cook, 2000).

**Setting:** The study was conducted in Faculty of Nursing, Cairo University.

**Informants:** Total informants of 8 senior male and female nursing students were adopted purposefully to participate in the study. Nelson (1996) supported purposeful sampling for qualitative research as a way to reveal the most information about the phenomenon under study. A criterion sample to be a strategy that is used where all informants have experienced the phenomenon. The informants would have to meet the criterion requirement, which includes participating in the phenomenon. Therefore, criteria for inclusion in this study would be (1) Undergraduate senior nursing students who passed all courses involving clinical training with cancer patients through Medical-Surgical, Oncology and / or Critical Care Nursing; (2) Students who had previous experiences of cancer nursing patients were eligible to participate; and (3) Students who express their willingness to participate and give permission for the interview to be recorded on audiotape will be eligible to participate. Informants were only selected until saturation or redundancy of responses was determined. Interview of informants were stopped when no new information was heard about the study phenomenon.

**Tools and Pilot Study:** Unstructured interview was used as a method of data collection. The researcher developed 13 research questions that were used as the foundation to develop the interview questions. A panel of experts were asked to review the research questions and the open-ended interview questions to provide feedback. The interview tool was revised based on the experts recommendations. With expert’s approval, two pilot interviews were conducted before conducting this study. From the data provided by the pilot interviews, the interview tool was finally revised.

The interviews included an open-ended questions specific to the purpose of the study: "Tell me about your experience of disclosure involving cancer patients"; "Tell me about your feeling, at that time being present during disclosure of information regarding diagnosis and prognosis and explain why?" – "Explain your views on disclosure and justify your view." – "Who will convey the truth about the diagnosis to the patient and his family and why?" – "Who are in the best position to receive the information about the patient’s diagnosis and prognosis first and why?" – "Factors which the informants will take into consideration when deciding whether to disclose information." "What do you think about the motivating factors to disclose the information?" – "What do you think about preventing factors?"- "What should be the components of the message, you convey to the patient regarding cancer?" – "What are the guiding principles of truth disclosure that you should apply in this situation?" – "What do you think about the consequences of this disclosure?"- "What are the benefits of disclosure?" – "What are the negative of consequences of this disclosure?"

These questions were formulated in the interview guide, which was generated from the issues identified in the investigators’ clinical practice, an extensive literature review, and in consultation with both methodological and clinical experts. Also, during the progress of the interviews, the informants requested further explanation for the questions which was dealt with by the interviewers.

**Procedure:**Once permission was granted, the nursing students who met the criteria for inclusion in the study was recruited. Personal data were collected through individual interviews. An audio tape was used to record the interviews. Two researchers collected the data, with one researcher serving as the interviewer while the other acted as a moderator, taking field notes and operating the audio tape recorder. To maintain confidentiality, identifiers in the form of dates and numbers were used to label the audio tapes. The transcripts from the audio tapes were anonymous. The research questions were: “What are your views regarding disclosure of patients’ information regarding cancer?” followed by probing questions that sought clarification of participants’ initial response. Interview times ranged from 45 minutes to 1.30 hours. The interviews ceased when data saturation was reached, that is, when information was repeated without any new views being presented. After each interview, the recordings were transcribed. The researchers read and re-read the data and constructed a coding frame, and then examined themes, across the whole data set, and in the context of each individual’s interview. The informants’ narratives were analyzed using qualitative methodology.

**Statistical Analysis :** The data were analyzed according to the steps outlined by Tesch. They were transcribed verbatim from the audio tapes. The audio tape transcripts were read and re-read by the researchers to make sense of the whole. Data reduction was used in the data analysis process. The researchers identified essential features and patterns of the data, such as extracts from the interviews that represented extracts of the same nature. The data were clustered together into similar topic themes and then organized into categories. The field notes written during the data collection were used to gain the necessary background information. The content of each category was summarized in order to draw conclusions. Literature was used to support the findings. The two researchers then coded the transcripts independently. This was followed by recoding, after which discussions were undertaken by the two researchers until consensus was reached about the themes and categories. After that, the researchers conducted an independent quality check and verified the findings.

**Ethical consideration:** Permission to conduct the study was requested and obtained from the authoritative committee personal. Nursing Students who voluntarily agreed to be involved in the study; following a thorough explanation of the purpose of the study. Informed written consent was obtained from the participants to be interviewed and make audio recordings. Also, nursing students were assured that they could withdraw from the study at any time, without penalty, if they so wished. Only the research team knew the names of the individual informants. The informants were allowed to ask questions. They were explained to them that the study would be significant in reinforcing the importance of disclosure of information in patient care. It was also explained that the study findings would be disseminated in the form of presentations at conferences and publication in an accredited journal.

**Results:** The presentation of data will proceed as follows: (I) Nursing students disclosure experience which include: (a) Informants perspective of the word cancer; (b) Cancer diagnosis disclosure experience, (c) Who the best person to tell about cancer diagnosis, (d) Who is in the best position to receive information about the patient's diagnosis and prognosis at first, (e) Component of disclosure information about cancer, and finally (f) The guiding principles of truth disclosure; (II) Three main themes emerged from analysis of the data including: (1) Factors influencing the disclosure of information, (2) Opportunities that may facilitates truthful disclosure of information, (3) Challenges that may face truthful disclosure of information.

**(I) Nursing students disclosure experience:** The eight senior nursing students who volunteered to participate in the study, three were female and five were male and their ages ranged from 20 – 22 and mean age was 21.63. All the informants were single. The entire informants were in the final year of study except for three, who were in third year. They had already attended the clinical training in the area of medical-surgical, oncology as well as critical care nursing.

1. **Informants perspective of the word cancer:** All informants considered that the word “cancer” often accompanies feelings like fear of death, loss of hope, anxiety, shock and suffering.

الشعور المصاحب لسماع كلمه سرطان يعني "خوف من الموت" "فقد الأمل" "قلق" "صدمه" "معاناة "

Three from eight informants oppose the use of term “Cancer”, and believed this term should not be used directly and should be replaced with a word with much less negative impression like tumor, in an attempt to not be specific. In spite of, all informants were in favor of informing and providing full information to the newly diagnosed cancer patient about the diagnosis, they believed that it is the patient's right to know and the truth should be known to patient gradually. Some of the informants mentioned the following:

"طبعا من حقه يعرف و لكن صعب أقوله كلمة سرطان" "لازم يعرف و لكن بالتدريج و استعمل كلمة ورم بدلا من سرطان"

**(b) Cancer diagnosis disclosure experience:** As regarding to cancer diagnosis disclosure experience to the patient; all informants were considered as shock, anxiety, fear of a negative impact on the patient and from patient's reaction. The narratives were as follows:

تجربه المصارحة أو المكاشفة كانت "صدمه صعبه و بشعة" "مصحوبة بالكثير من القلق و التوتر و الرعب مصحوب بخوف من رد فعل المريض"

**(c) Who the best person to tell about cancer diagnosis:** Four informants considered that communicating new medical diagnoses and their prognosis is traditionally a physician’s responsibility, and only 3 informants considered that the nurses were the best person to tell about cancer diagnosis. Only one informant considered it as health team responsibility from doctors and nurses should be concerned with such issue. Some of the narratives revealed the following:

" الدكتور المتابع لحالته الذي يثق فيه و يقتنع برأيه حتى يتقبل المعلومة" "الممرضة التي تقضي معظم الوقت معه و بينهما ثقة و علاقة طيبه " " الدكتور و الممرضة معا"

**(d) Who is in the best position to receive information about the patient's diagnosis and prognosis at first:** From own point of view of informants regarding who is in the best position to receive the information about the patient’s diagnosis and prognosis first. All informants indicated that relatives to be present to support the patients during disclosure of information about cancer. Some of the narratives were as follows:

"احد أفراد العائلة من الأقرب إلي المريض و يثق فيه لمساندته و دعمه عند استقبال المريض بالتشخيص"

**(e) Component of disclosure information about cancer:** In relation to components of information about cancer were: 1) Nature of disease; 2) Risk Factors related to disease; 3) Signs, symptoms and diagnosis method 4) Treatment options, its complications, and how to deal with complications; 5) Self care and rehabilitation after recovery; 6) Prognosis of disease. The following was highlighted:

"التعريف بطبيعة المرض""عوامل الخطورة المسببة للمرض" "الأعراض و كيفية اكتشافها" "طرق العلاج؛مضاعفات العلاج و كيفيه التغلب عليها" "التأهيل بعد الشفاء و العناية الشخصية" "احتمال شفاء المرض"

**(f) The guiding principles of truth disclosure:** The guiding principles of truth disclosure that health care professional should apply in this situation from informants own point of view were: 1) Create a comfortable setting in proper time and place, manage interruptions 2) Trust relationship between patient, family and health care team, 3) Ensure privacy., 4) Involve significant others, such as family/caregiver in discussion 5) Presence of good role model, 6) Build therapeutic relationship, communicate well with patient's, family (good listening, eye contact, proper body language); and 7) Health care provider who disclose information must be knowledgeable about disease, 8) Responding to the patient's emotions with empathic responses. Informants commented as follows:

"اختيار المكان المناسب الهادئ و الوقت الكافي دون تدخلات" "العلاقة الوثيقة بين أفراد الفريق الطبي و المريض و أسرته" "الاهتمام بخصوصية المريض" "وجود الأقرب للمريض" "وجود مريض مر بتجربة ايجابيه و ناجحة مع المرض" "التركيز مع المريض- الاستماع جيدا – إعطاء الوقت الكافي ليرد علي أسئلة المريض بصدر رحب" "التجاوب و المشاركة الوجدانية مع رد فعل المريض مع مراعاة مشاعر المريض " من يخبر المريض بطبيعة المرض يجب أن يكون لديه المعلومات الكافية و الاستعداد للرد علي أسئلة المريض"

**(II) Three main themes emerged from analysis of the data were:**

1. **Factors influencing the disclosure of information:** All informants listed their views about five main important factors in priority which health care professionals should take into consideration when deciding whether or not to disclose a cancer diagnosis: 1) Strength of Self-religiosity; 2) Good role model about cancer; 3) Presence of Psychological support / family support system, 4) Level of education; 5) The patient had readiness to listen and accept the diagnosis. All informants thought that all this factors must be considered to avoid negative consequence of disclosure of information. The narratives were as follows:

"الارتباط و الإيمان بالله و الروحانيات" "وجود نموذج جيد يحتذي به لأحد المرضي الذين تغلبوا علي المرض " " وجود الأهل أو الصديق المقرب الموثوق في كلامه لمساندته" " مستوي التعليم" " استعداد المريض النفسي لسماع و تقبل التشخيص"

1. **Opportunities that may facilitate truthful disclosure of information:** All informants were ranking the motivating factors to disclose the information as: 1) Strength of Self-religiosity; 2) Educational level and health literacy; 3) Good psychological status of patient; 4) Presence of family support system; and 5) Expectation of patients and prior illness experience. The following was highlighted:

"الارتباط و الإيمان بالله و الروحانيات" " مستوي التعليم"" الاستعداد النفسي للمريض لسماع و تقبل التشخيص" "وجود الأهل أو الصديق المقرب الموثوق في كلامه لمساندته" "توقع المريض للمرض و الخبرة السابقة لدي المريض"

From informants own point of view in priority; the benefits of disclosure were: 1) Adherence to management regimen 2) Cooperation of patient during execution of treatment plan; 3) Adherence during follow –up, 4) Build good relationship between patient, family and medical team; and 5) Sense of hope and adaptation. Some of the narratives revealed the following:

" لكي يستجيب و يشارك في وضع الخطة العلاجية مع الالتزام بالعلاج" "التعاون و المشاركة في العلاج""الالتزام و الاهتمام بالمتابعة" " بناء علاقة طيبه علي أساس من الثقة و التقبل و الصدق بين المريض و الأهل و المعالجين " " الإحساس بالأمل ليستطيع التكيف مع المتغيرات"

1. **Threats/Challenges that may face truthful disclosure of information:**

The informants ranked the preventing factors to disclose the information as: 1) Weak Self-religiosity; 2) Absence of family support and poor psychological status as hopelessness from recovery; 3) Age of the patient is considered the challenging factor facing information disclosure as younger aged patients is most difficult to be informed; 4) Cancer staging, especially terminally stage cancer; 5) Misconception about disease. Informants commented as follows:

"ضعف الإيمان" " عدم وجود الدعم الأسري و الحالة النفسية السيئة للمريض كاليأس من الشفاء" "سن المريض بالأخص الأصغر سنا" "المراحل المتأخرة من المرض" "المعتقدات الخاطئة عن مرض السرطان"

So, the informants think about the negative consequences of this disclosure if this factors not considered as: 1)Non-adherence to therapeutic regimen such as medication and food; 2) Shock, Loneliness and Hopelessness; 3) Fear, Anxiety and Careless regarding performance of social role as job, education, or any responsibilities; 4) Fatalistic thinking / Death, 5) Finally but rare, suicidal. The following was highlighted:

"الامتناع عن العلاج و الأكل" "صدمه مع الميل إلي العزلة و اليأس من الحياة" " خوف و قلق مما يؤدي إلي الإهمال في مسئوليه المريض تجاه العمل و المنزل أو التعليم" " التفكير في الموت" " قد ينتابه نادرا رغبه في الرغبة في الانتحار"

Moreover, All of the informants revealed that in their whole educational experience, especially in relation to studying of behavioral sciences, there was lack of the clinical application aspects that prepared them to handle difficult clinical patients situation such as truth-telling.

**Discussion:** The discussion of the research result will be presented in two main sections as follows: (I) Nursing students disclosure experience; (II) Three main themes emerged from analysis of the data.

**(I) Nursing students disclosure experience:** Nursing students disclosure experience which include: (a) Informants perspective of the word cancer and cancer diagnosis disclosure experience, (b) Who the best person to tell about cancer diagnosis, (c) Who is in the best position to receive information about the patient's diagnosis and prognosis at first, (d) Component of disclosure information about cancer, and finally (e) The guiding principles of truth disclosure.

1. **Informants perspective of the word cancer and cancer diagnosis disclosure experience:** Disclosure of the cancer diagnosis is a difficult task for health care providers; as research informants were exposed to clinical and academic environments through the course of their study, they believed that the word “cancer” often is accompanied by feelings like fear of death, loss of hope, anxiety, shock and suffering and thus cancer diagnosis disclosure experience to the patient is considered as shock, anxiety provoking, fear of a negative impact on the patient and from patient's reaction. Three from eight informants oppose the use of term “Cancer”, and believed this term should not be used directly and should be replaced with a word with much less negative impression like tumor, in an attempt to not be harmful to patients' feeling. All informants were in favor of informing and providing full information to the newly diagnosed cancer patient about diagnosis, as they considered it as one aspects of patient's right.

Lending support to this speculation, Elsiddek, Eltayeib, Salahedin, Elbakhiet, Ibnouf (2014); Al-Amoudi (2013) and Tsoussis, Papadogiorgaki, Markodimitraki, Delibaltadakis, Strevinas, Psyllakis, Tabakaki, Drossitis, Kabourakis, Papadimitraki, Krypotos, Daskalakis, Fragiadaki, Zoumadaki, & Apostolakis, (2013) mentioned that disclosing to a patient that they have cancer is a critical, but sensitive issue. Although there has been great progress in cancer diagnosis and treatment, some still envision the diagnosis of cancer as a sentence of death, also believed that diagnosis should be delivered with vague wording considering the emotional and social status of patient, not using the word cancer and tell to have mass or lump without explaining its nature.

Nonetheless, telling the patient the truth is not only an ethical issue and a way of building confidence within the doctor -patient relationship, but also a patient’s right (Matlakala and Mokoena, 2011). Despite general agreement about the benefits of open communication between professionals and patients, there is still strong resistance against disclosure of cancer diagnosis and prognosis in many cultures, particularly in Asian, Middle- Eastern and Mediterranean regions (Sato, Beppu, Iba & Sawada , 2012, and Beyraghi, Mottaghipour, Mehraban, Eslamian & Esfahani , 2011).

1. **Who the best person to tell about cancer diagnosis:** All informants considered that communicating about new medical diagnoses as cancer and their prognosis is traditionally a health care professionals responsibility; four informants were consider it as a physician’s responsibility, and only three informants considered that the nurse were the best person to tell about cancer diagnosis. Only one informant considered it as health team responsibility including both doctors and nurses. Sarafis, Tsounis, Malliarou & Lahana (2014); Hancock, Clayton, Parker, Sharon, Butow, Carrick, Currow, Ghersi, Glare, Hagerty & Tattersall (2007) and Costantini, Morasso, Montella, Borgia, Cecioni, Beccaro, Sguazzotti & Bruzzi (2006) stated that in most cases, a physician is the one that disclosed the diagnosis of cancer. A very small proportion of other health professionals (nurses, social workers and psychologists) disclosed cancer diagnosis (0.5%) or poor prognosis (0.9%).

Reasons include the health care professionals refrain from truthful disclosure to cancer patients are perceived lack of training, stress, no time to attend to the patient’s emotional needs, fear of a negative impact on the patient, uncertainty about prognostication, requests from family members to withhold information and a feeling of inadequacy or hopelessness regarding the unavailability of further curative treatment (Hancock, Clayton, Parker, Wal-der, Butow, Carrick, Currow, Ghersi, Glare, Hagerty & Tattersall, 2007, Costantini, Morasso, Montella, Borgia, Cecioni, Beccaro, Sguazzotti & Bruzzi, 2006 and Back & Arnold, 2006).

1. **Who is in the best position to receive information about the patient's diagnosis and prognosis at first:** All informants thought that the relatives are in the best position to receive the information about the patient’s diagnosis and prognosis first, to be prepared to provide support to the patients during disclosure of information about cancer. Jawaid, Qamar, Masood, Jawaid (2010), research conclusion revealed that the majority of doctors both in developed and developing countries tell the truth more often today than in the past, but some, especially in developing countries prefer to disclose this diagnosis to the next of kin. These go on the same vein with Sheu and Mu (2008) who reported that in family-orientated countries such as Spain, Italy, Greece, Saudi Arabia, Egypt, Singapore, Japan and China, the family assumes the responsibility of decision-making for the patients and the majority of physicians prefer to disclose the truth on cancer diagnosis and prognosis to the next of kin to protect the patients from unnecessary despair and a feeling of hopelessness by excluding them from the process of information exchange.
2. **Component of disclosure information about cancer:** According the informants points of view, disclosure of accurate information may help to decrease patients’ negative experiences and increase their active involvement in treatment plans, so during the treatment phase, all informants suggested that patients with cancer seek information about cancer in terms of its nature; signs and symptoms; risk factors related to disease, treatment options, its complications, and how to manage them; self care and rehabilitation after recovery; and prognosis of disease especially extent of disease spread and chances of cure.

This view point was supported by study findings of Sarafis, Tsounis, Malliarou & Lahana (2014) and Smith, Dow, Virago, Khatcheressian, Matsuyama and Lyckholm (2013) research which stated that patient with cancer seek information about cause, diagnosis, treatment plan, potential side effects, prognosis, psychosocial aspects of their illness, and the potential impact of these aspects on their quality of life. They added that an appropriate disclosing technique can give patients a sense of control, increasing their hopefulness. Being able to confide in doctors their fear, they may improve their ability to cope with their suffering , improving patients' psychosocial well-being and coping abilities (Sarafis, Tsounis, Malliarou, and Lahana, 2014).

**(e) Guiding principles of truth disclosure:**Therefore the informants of the current study reported their views about the guiding principles of truth disclosure that should be applied with cancer patients according to the following order: 1) Create a comfortable setting in proper time and place, manage interruptions 2) Building a trust relationship, between patient, family and health care team, 3) Ensure privacy., 4) Involve significant others, as family/caregiver in discussion 5) Presence of good role model, 6) Build therapeutic relationship, use proper communication skills with patients and family through good listening, eye contact, proper body language; and 7) Health care provider who disclose information must be knowledgeable about disease, 8) Responding to the patient's emotions with empathy. This view point of informants go in accordance with Balle, Buckman, Lenzi, Glober, Beale, Kudelka (2000), as they recommended that the task of breaking bad news can be improved by understanding the process involved and approaching it as a stepwise procedure, applying well-established principles of communication and counseling. The six steps of spikes as (1) Setting up the interview; (2) Assessing the patients' perception, (3) obtaining the patient's invitation, (4) giving knowledge and information to the patient, (5) Addressing the patient's emotions with empathetic responses, and (6) Strategy and summary. Elsiddek, Eltayeib, Salahedin, Elbakhiet, Ibnouf (2014) concluded that truth telling practice and preferences is a cultural artifact to certain extent. Honest and truthful disclosure is an extremely difficult task. Physicians often find the disclosure of cancer diagnosis to the patient as an embarrassing job. Few healthcare workers have received sufficient training in the “breaking bad news” tactics.

**(II) Three main themes emerged from analysis of the data:**

Three main themes emerged from analysis of the data including: (1) Factors influencing the disclosure of information, (2) Opportunities that may facilitate truthful disclosure of information, (3) Challenges that may face truthful disclosure of information.

1. **Factors influencing the disclosure of information:**

All informants suggested five main important factors in priority which should be taken into consideration when deciding whether to disclose a cancer diagnosis: 1) Strength of Self-religiosity; 2) Availability of good role model about cancer; 3) Presence of Psychological support / family support system, 4) Level of education; 5) Patient's readiness to listen and accept the diagnosis. All informants thought all this factors must be considered to avoid negative consequence of disclosure of information. Fallowfield and Jenkins (2004) stated that how bad, sad, or difficult information is received depends on many factors, including expectations, previous experiences, and general personality disposition. Shock, horror, anger, stoic acceptance, disbelief, and denial are all possible reactions and anyone charged with breaking bad news needs to be able to cope with these emotions.

Tsoussis, Papadogiorgaki, Markodimitraki, Delibaltadakis, Strevinas, Psyllakis, Tabakaki, Drossitis, Kabourakis, Papadimitraki, Krypotos, Daskalakis, Fragiadaki, Zoumadaki, Apostolakis, (2013) added that 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.

1. **Opportunities that may facilitates truthful disclosure of information:**

In current study, all informants were ranking the motivating factors to facilitate the disclosure of information as: 1) Strength of Self-religiosity; 2) Educational level and health literacy; 3) Good psychological status of patient; 4) Presence of family support system; and 5) Expectation of patients and prior illness experience. Öksüzoglu, Abalı, Bakar, Yıldırım and Zengin (2005) found that high education status positively affected this tendency, possibly due to the fact that being better informed leads to less fear from cancer and perhaps because of greater confidence in developing treatment strategies and more exposure to Western trends and values. Unmarried people were younger and better educated, and this may be the explanation for the positive tendency for them to favor disclosure to the patient.

Regarding the assumption that truth-telling is always beneficial to patients; the findings revealed that all informants had listed the benefits of disclosure as: 1) Adherence to management regimen 2) Cooperation in treatment modalities; 3) Adherence during follow –up, 4) Build good relationship between patient, family and medical team; and 5) Creating a sense of hope and ability for adaptation. Tsoussis, Papadogiorgaki, Markodimitraki, Delibaltadakis, Strevinas, Psyllakis, Tabakaki, Drossitis, Kabourakis, Papadimitraki, Krypotos, Daskalakis, Fragiadaki, Zoumadaki, Apostolakis, (2013) and Kazdaglis, Arnaoutoglou, Karypidis, Memekidou, Spanos and Papadopoulos (2010) found that the benefits anticipated from disclosure of information were as follows: patient-professional cooperation (88%), patient’s compliance (82%), arrangement of patient’s pending personal issues (75%), avoidance of repeated questions (37%), and others such as 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.

In general, Woldemariam, (2012) mentioned the benefits of providing patients with information include increased satisfaction with and participation in the consultation, decreased anxiety, and increased ability to cope. Also, Fallowfield and Jenkins (2004) mentioned that effective delivery of bad news can result in patients who are the following: (1) Better informed; (2) More motivated to follow through with further evaluation and treatment; (3) Less emotionally distressed; (4) Better able to ask questions and participate in the clinical encounter; (5) Better prepared to make treatment decisions; (6) Better able to navigate the health care system; (7) Clear about the level of uncertainty of the diagnosis.

1. **Threats/Challenges that may face truthful disclosure of information:**

The informants ranked threads and challenges that may sever as preventing factors as: 1) Weakness of Self-religiosity; 2) Absence of family support and poor psychological status resulting from sense of hopelessness of recovery; 3) Age of the patient is considered a challenging factors facing information disclosure as younger in age that is most difficult to be informed; 4) Cancer staging, especially terminally stage cancer; 5) Misconception about disease. In this regards, Baile, Buckman, Lenzi, Glober, Beale, Kudelka (2000) mentioned that breaking bad news to cancer patients is inherently aversive, described as “hitting the patient over the head” or “dropping a bomb”. Rahman, Mahmud, and Mohamed (2010) added that breaking bad news can be particularly stressful when the clinician is inexperienced, the patient is young, or there are limited prospects for successful treatment.

So, the informants stated their views of the factors to be considered as indicative of the negative consequences of disclosure as: 1)Non-adherence to therapeutic regimen as medication and food; 2) Shock, Loneliness and Hopelessness; 3) Fear, Anxiety and Careless regarding performance of social role as job, education, or any responsibilities; 4) Fatalistic thinking / Death, 5) Finally but rare, suicidal. Innes and Payne (2009) stated that evidence suggests there are potentially negative consequences for an individual who lacks insight into their disease stage. These include unsatisfactory management of the advanced stage of illness, such as unnecessary (and unwanted) hospital admissions, a higher proportion of hospital deaths and a lack of, or late, referral to palliative care services, poorer symptom control, less end-of-life planning and consequently reduced patient choice. In addition, psychological consequences are documented, including increased mistrust and feelings of abandonment in patients. It is important of course, to understand that disclosing such negative news might result in a loss of hope, but still worse is hiding this information, which could have a far more negative impact on the management and adherence of a treatment plan in addition to denying the patient the right of choice, which is considered among the most basic health and human rights (Neiders, Sile & Silis, 2013 and Back & Arnold, 2006).

**Conclusion:** The delivery of sad, bad, and difficult news will always be an unpleasant but necessary part of medicine. In the current study, all informants reported that it is difficult to engage in open communication with the patients, because their academic education did not sufficiently train them in communication skills. These results indicate that although many nursing student believe that the patients should be informed and know their condition, lack of training in communication skills and emotional capabilities is a major obstacle to achieving this. So, Training health-care professionals how to do the task more effectively will produce benefits for them as well as their patients, but this training needs to be based on sound educational principles, informed by evidence, and assessed and monitored adequately. Future training initiatives may need to include more about ethics and team approaches to the delivery of bad news to ensure appropriateness and consistency of the message being delivered. Clear guidelines must be integrated in the academic education of health care professionals, as also in their continuous in-service education to upgrade professional-patient communication.

**Recommendation:** The following implications and recommendations were considered based on the findings of this study: (1) Integrate appropriate communication skills, teaching and spiritual care into undergraduate and postgraduate education in order to use appropriate approach to handle patient's reaction., (2) Since disclosure of information is a process of reciprocal concern to both patients and health care professional, a qualitative research concerning patients’ perspectives on prognostic disclosure and emotional responses to such information is recommended, in order to provide appropriate way of conveying information to cancer patient., and (3) Meanwhile, further research about clinicians and patients attitudes towards revealing the truth during a serious illness and the influence of social and cultural context above them is definitely needed; in different countries and cultures., and (4) Replication of the study in other setting.

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