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The Differences in Preference for Truth-telling of Patients With Cancer of Different Genders

KEY WORDS

Cancer
Gender difference
Qualitative research
Truth-telling

Background: Patients' personality traits, especially age, gender, and cancer stage, tend to affect doctors' truth-telling methods. However, there is a lack of studies investigating the influence of patients' gender on truth-telling, especially for Asian cultures. **Objective:** The aims of this study were to qualitatively investigate the differences in preferences for truth-telling for patients with cancer of different genders and explore patients' preferences for decision making. **Methods:** For this descriptive qualitative study, in-depth interviews were conducted with 20 patients with cancer (10 men and 10 women) using a semistructured interview guide. All interviews were audiotaped and transcribed verbatim. Data collection and analysis occurred concurrently; content analysis developed categories and themes. **Results:** Data analysis revealed 2 themes: (1) similar gender preferences for truth-telling and decision making: knowledge of their medical condition, direct and frank truthfulness, and assistance in decision making for subsequent treatment programs, and (2) preferences in truth-telling that differed by gender: women wanted family members present for confirmation of diagnosis, whereas men did not; men preferred truth-telling for only key points of their cancer, whereas women wanted detailed information; and men did not want to know their survival period, whereas women wanted this information. **Conclusions:** Our study revealed similar gender preferences for truth-telling regarding knowledge and decision making; however, preferences differed for family support, scope of information, and survival time. **Implications for Practice:** These findings can serve as a reference for nurses

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and other healthcare personnel when implementing truth-telling for patients given a diagnosis of cancer. Strategies can be targeted for specific preferences of men and women.

According to the statistics of the Ministry of Health and Welfare, cancer has been the leading cause of death in Taiwan since 1982. In 2014, the number of patients who died of cancer reached 46,094, which exceeded the total in 2013 by 1303 (30% of all deaths).¹ This trend in increased numbers of patients with cancer has resulted in the implementation of truth-telling by doctors becoming a daily routine. Truth-telling is a strategy for communicating unfavorable medical information, or “bad news,” which refers to any information that may adversely and seriously affect an individual's view of his/her future or lead to long-term psychological and behavioral issues.^{2,3}

Past studies found that, if patients with cancer learned of their medical condition, they were more likely to cooperate with treatment, which contributed to a greater likelihood of extending their survival period.^{4–6} For patients with advanced-stage cancer, learning of their condition can contribute to a greater inclination to make choices that are beneficial to themselves, reduce ineffective or harmful medical treatments, and also significantly decrease uncertainty and anxiety.^{4,7,8} Accurate information about their diagnosis can assist patients in sharing their feelings and discuss treatment options with family members as their cancer progresses; this may also allow patients sufficient time to fulfill their last wishes and bid farewell to family members and friends.^{9,10}

Understanding how patients prefer truth-telling to be implemented is a significant challenge for doctors. Patients differ in their personal and medical characteristics such as educational background, economic status, gender, cultural background, and cancer stage, which can influence doctors' truth-telling methods, especially with regard to patients' age, gender, and cancer stage.¹¹ Studies on truth-telling have focused on investigating cultural differences^{4,12–17} or the effectiveness and importance of training healthcare providers in truth-telling communication skills.^{18–21} Culturally, Western countries prefer direct truth-telling,^{15,16,22} which is influenced by an emphasis on patients' desire for autonomy.^{4,14} In contrast, eastern countries are more family centered,^{15–17} and indirect truth-telling is more culturally acceptable.^{15,16,22} Families in eastern cultures often prefer non-disclosure or partial disclosure to protect the patient.^{16,17}

Preferences for truth-telling can also differ by gender. Gender differences in truth-telling have been described for western cultures^{23–25}: men and women differ in how they prefer the news of cancer to be communicated,²³ family members of male patients are more likely to not want the diagnosis of cancer disclosed,²⁴ and men pay greater attention to medical information, whereas women hope to obtain emotional and social support.²⁵ However, none of these studies investigated the possible causes for such gender differences. Moreover, there is a lack of relevant studies regarding truth-telling for patients with cancer in Asian countries. Therefore, a qualitative inquiry was conducted to fill this information gap from an eastern perspective. The purpose

of this study was to explore gender differences for patients with cancer in truth-telling, as well as patients' preferences for decision making, in Taiwan.

■ Methods

Design

We used a descriptive qualitative design to explore gender differences in the experiences of patients with cancer regarding preferences for truth-telling. A descriptive qualitative design can be used for smaller-scale naturalistic inquiries to yield a rich description of patients' experience in their own language.^{26–28}

Study Setting and Participants

Potential participants were purposively sampled from 2 medical centers concurrently to select participants who were rich in information. The researcher proposed this project to the oncology committee of the 2 study sites. Physicians provided the information on those patients meeting the inclusion criteria. Patients were eligible if they were older than 18 years, given a diagnosis of cancer for at least 1 month, or able to communicate in Chinese or Taiwanese and agreed to participate in the study. The researcher explained the study design to the eligible patients, and participants signed a written informed consent. This study enrolled a total of 20 patients with cancer (10 men and 10 women). Participants' mean (SD) age was 52.2 (12.47) years, most participants' educational background was less than high school completion (60.0%), economic status was middle income (55.0%), and most were given a diagnosis of either lung cancer (60.0%) or breast cancer (35.0%) (Table 1).

Ethical Considerations

The institutional review board of Chang Gung Memorial Hospital (99-2469B) reviewed and approved the study. The corresponding author explained the study purpose to the eligible patients. Patients were informed that they could withdraw from the study at any time, and for any reason, without any consequences regarding their rights to receive continued medical treatment and that their data would be kept confidential and used only for academic purposes. Enrolment and initiation of the study occurred after patients signed the written informed consent form.

Data Collection and Analysis

Data were collected through open-ended, semistructured interviews. An interview guide (Table 2) with open-ended questions was developed by the corresponding author and informed by the literature,¹⁵ experiences of clinicians, and joint discussions with experts from the Academic Research Group of Taiwan Psycho-Oncology Society. All interviews were tape-recorded with

 **Table 1 • Participants' Characteristic**

No.	Gender	Age, y	Education	Economic Status	Cancer Type	Cancer Stage
1	F	30	College	Moderate	Breast	Recently diagnosed
2	M	53	Junior high	Enough	Lung	Recently diagnosed
3	M	52	Junior high	Less	Lung	Recently diagnosed
4	M	53	Junior college	Moderate	Lung	Recently diagnosed
5	F	50	Senior high	Moderate	Lung	Recently diagnosed
6	F	47	Junior college	Less	Lung	Recently diagnosed
7	M	77	Junior high	Moderate	Lung	Recurrence/metastasis
8	M	35	College	Moderate	Lung	Recently diagnosed
9	M	60	College	Moderate	Lung	Recently diagnosed
10	F	44	Junior college	Moderate	Breast	Recurrence/metastasis
11	F	63	Junior high	Moderate	Breast	Recurrence/metastasis
12	M	69	Junior high	Less	Liver	Recently diagnosed
13	F	76	Primary	Moderate	Breast	Recently diagnosed
14	F	55	Junior high	Enough	Breast	Recently diagnosed
15	M	42	Senior high	Less	Lung	Unclear
16	F	59	Junior college	Less	Lung	Terminal
17	F	41	Junior high	Less	Breast	Recurrence/metastasis
18	M	48	Master	Enough	Lung	Recurrence/metastasis
19	F	42	College	Moderate	Breast	Recurrence/metastasis
20	M	48	Junior college	Moderate	Lung	Recently diagnosed

Abbreviations: F, female; M, male.

participants' permission. During the interviews, the researcher excluded personal perspectives to reduce subjective deviation. Interviews lasted an average of 53.4 minutes. Demographic data were collected with a structured questionnaire after the interview. Cancer type and stage were obtained via chart review.

Analysis and data collection were conducted concurrently.²⁹ Conventional content analysis was used to analyze the interview data guided by the strategies of Hsieh and Shannon³⁰ for developing codes, categories, and themes.^{30–33} All data were analyzed by the first and corresponding authors. Tape-recorded interviews were transcribed verbatim by a research assistant and coded using the participants' words to represent their experiences and perceptions. Themes were derived from clarification of the relationships among different categories.

Trustworthiness of the data was ensured by meeting 4 criteria: credibility, transferability, dependability, and confirmability.³⁴ Credibility and transferability were enhanced by using the triangulation method, in which the 2 authors jointly analyzed the interview data and reached consistency through discussions; bracketing personal views to reach an impartial attitude; checking unclear statements to clarify and reconfirm participants' views; and using purposive sampling to include a variety of participants, which provided thick descriptions through interviews. Dependability and confirmability were enhanced by fully retaining relevant data collected from interviews and analyses, to build an audit trail.

■ Results

This study interviewed 20 patients with cancer (10 men and 10 women) to obtain data regarding gender preferences for truth-telling of patients with cancer. Analysis of the interview data revealed 2 major themes: (1) gender similarities in preferences

for truth-telling and (2) gender differences in preferences for truth-telling. The relationship between the categories and themes is shown in the Figure.

Gender Similarities in Preference for Truth-telling

The gender similarities for truth-telling had 3 underlying categories: willingness to learn about the medical condition, deciding about subsequent treatment programs, and truth-telling methods, which are identified in the shaded portion of the Venn diagram shown in the Figure.

WILLINGNESS TO LEARN ABOUT MEDICAL CONDITION

All participants indicated that they intended to learn about their medical condition. One patient's family concealed the truth at the beginning of diagnosis because they were afraid that the

 **Table 2 • Semistructured Interview Guide**

Questions
(1) How did you learn that you had cancer?
(2) What were your feelings and experience when the doctor broke the bad news to you?
(3) If the doctor had a chance to break the bad news to you again, what would your expectation toward him/her be? Why?
(4) If the doctor had a chance to break the bad news to you again, what would you hope he/she not to do? Why?
(5) At this stage of your disease (recently diagnosed, recurrence/metastasis, or terminal), what do you wish the doctor should pay attention to during implementation of truth-telling?
(6) Is there anything that is not included in this interview that you would like to share with me about the topic discussed today?

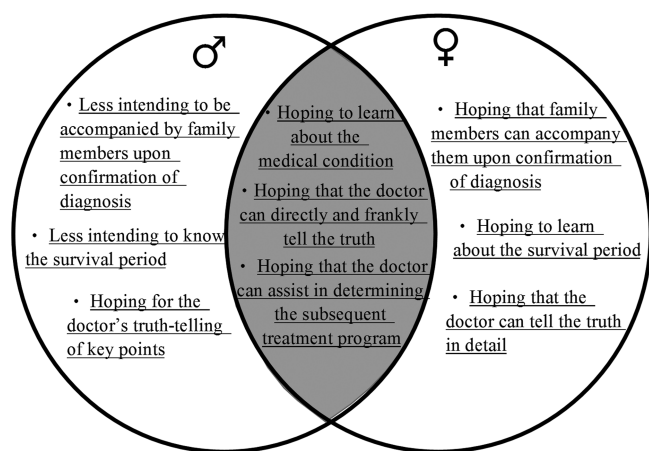


Figure ■ Influence of gender on preference for truth-telling.

patient would worry about his disease. Therefore, the patient intended to learn more of all aspects of the medical condition after knowing the truth.

I just wanted to know the truth and whether my cancer could be treated or not. If it could be treated, how long would I survive after the treatment (surgery)?...Actually, it's no big deal. Just tell me the truth without concealment! (P12, 69 years old, male)

DECIDING ABOUT SUBSEQUENT TREATMENT PROGRAMS

After truth-telling, most patients could proactively ask about the subsequent treatments, but because there are many treatments of cancer, each one has its own advantages and disadvantages. This study found that most patients with cancer hoped that doctors could assist them in making therapeutic choices because they believed in the medical profession.

I believe in my doctor, because doctors care about their patients just like parents care about their child. I'll follow my doctor's instructions to receive treatments, whatever they are. (P3, 52 years old, male)

A few patients still intended to make decisions on their own or make decisions after the discussion with doctors. These few patients were young and had a medical background or a higher educational background.

I think patients are entitled to the decision-making power.... the doctor should negotiate with me about my treatment without making a decision unilaterally. Therefore, I feel that it is preferable to have patients clearly understand their own disease and make subsequent decisions on their own. (P6, 47 years old, female)

TRUTH-TELLING METHODS

All participants hoped that doctors could directly and frankly tell them the truth without concealment or using euphemisms. They consistently suggested that only when told the truth honestly could they know how to cooperate with the treatment or make adjustments in life and work.

I think that doctors should tell me the truth clearly without concealment. To be honest, this way is better for me.

Sometimes, my doctor will avoid the important and dwell on the trivial. For example, I asked him whether I suffered from cancer.... However, he told me, "You don't have to worry about it. It's easy to treat lung adenocarcinoma." He didn't have to particularly explain to me about my treatment. He could have directly told me what my disease is. (P8, 35 years old, male)

I feel that it's better to directly tell the truth, because I have been sick. Being sick is no big deal. Whoever is sick has to receive treatment or undergo surgery. There is no need to conceal the truth. (P14, 55 years old, female)

Influence of Gender on Differences in Preference for Truth-telling

Three underlying categories differed by gender in preferences for truth-telling: level of truth-telling, intention to learn of the survival period, and family members' participation in truth-telling.

LEVEL OF TRUTH-TELLING

Most male participants hoped that the doctor's truth-telling would include the key points of their disease, whereas female participants hoped that truth-telling would include greater details. Most male participants suggested that, if doctors provided too much information, they would not be able to memorize it all because they were nervous. Furthermore, they voiced concern that, because doctors are required to examine several patients every day, they would not have the time or energy to provide explanations in great detail.

It's acceptable that doctors tell the key points, because if doctors talk too much, patients are unable to memorize so much. (P8, 35 years old, male)

Just tell me the key points! Doctors have to see so many patients every day. When my doctor sees me, he will be too tired to give explanations in detail. (P7, 77 years old, male)

The few male participants who hoped that doctors could tell the truth in detail were mainly those with a higher educational background.

I hope my doctor could tell me the truth in detail, including the disease, stage, progression, therapeutic effect on me, and what to pay attention to in daily life. (P18, 48 years old, male)

Most female participants hoped that doctors could tell the truth in greater detail and suggested that detailed explanations could enable patients to better understand the disease progression, choose adequate treatments, and make arrangements for the future.

Of course, the more detailed the better. My doctor should tell me how to treat my cancer, what the treatment process is, and how the effect of the drug is because only when one is psychologically prepared can he/she make the best arrangements for life. (P19, 42 years old, female)

However, there were a few female participants who hoped that doctors would simply tell them the key points. In general, these participants were older and had a lower educational

background or poorer economic status. These participants believed that, if doctors gave very detailed explanations, they would be unable to understand the information, which would increase their level of stress.

My doctor only has to tell me the key points, because we do not understand medical knowledge. If my doctor told us too much, we would be very nervous as well.
(P16, 59 years old, female)

WILLINGNESS TO LEARN ABOUT THE SURVIVAL PERIOD

Most female participants hoped that truth-telling would include knowledge regarding length of survival. This was important to make plans for the future, which included arranging for the funeral and fulfilling their last wishes. However, only a few female participants actually proactively asked about the survival period, and doctors usually responded with silence or changed the topic.

I hope that I can be psychologically prepared for how long I can live or do what I haven't done in my life. I intend to make arrangements for the future, such as purchasing Columbarium Pagoda. (P11, 63 years old, female)

I requested my doctor to honestly tell me how long I could live. However, no one told me about it. Therefore, I told him again that I have to distribute my property. I think that my hint was clear, euphemistic, and reasonable. However, my doctor did not tell me and just gave me a smile. (P14, 55 years old, female)

Most male participants did not hope to learn about the survival period. They believed that the constant improvement in medical technologies might bring a change in the length of survival. Learning of the survival period would only increase their psychological burden.

I did not hope my doctors tell me the survival period, because I still have hope for the future. If my doctor told me that I could live for 10 years, would that mean my life certainly ended 10 years later? Perhaps there will be new drugs to immediately cure my disease.
(P8, 35 years old, male)

Telling me my survival period actually could not create any benefits to me.... (It) will only increase harassment and will not do me any good. (P7, 77 years old, male)

SUPPORT OR BURDEN

Family members accompany most patients during truth-telling of cancer information. Therefore, it is necessary to understand patients' opinions on family members' presence during the process. Truth-telling not only affected patients but also had a significant impact on family members. During the interviews, 1 participant described truth-telling as a "family turmoil."

Our study found that most male participants did not hope to be accompanied by family members. They suggested that the company of family did not create any benefits for the disease and family members' emotions would affect their own psychological preparation and become an invisible burden. One male

participant also suggested that the doctor should understand a patient's willingness to have family members present in advance, which would allow the doctor to send family members away and prevent the patient from being deprived of autonomy.

I don't think it's necessary to be accompanied by my family, because they probably cannot bear it at the moment of truth-telling, which will affect my mood and psychological state. I have to face my disease, and I also have to comfort their emotion. How can I deal with such a situation?
(P9, 60 years old, male)

If patients are unwilling to inform their family of the fact, then doctors can skillfully send away family members by giving them a slip which request them to take NHI IC card or appointment slip. (P9, 60 years old, male)

However, most female participants hoped to be accompanied by family members or friends. They suggested that family members and friends could assist them in understanding medical conditions and provide them with emotional support.

I was afraid that I didn't hear the cancer stage clearly, so I called my older sister.... After all, they (older sister and doctor) are medical and nursing personnel who are familiar with professional terms, and they could converse with each other rapidly and smoothly. (P16, 59 years old, female)

■ Discussion

Few studies have investigated the influence of gender on differences in preferences for truth-telling, especially with regard to Asian cultures. Our study found that there were gender similarities and differences in preferences for truth-telling in patients with cancer in Taiwan. Although 2 previous quantitative studies concerning truth-telling did not detect any significant difference in gender preferences,^{18,35} our findings are in agreement with several other studies showing differences in the preference for truth-telling between male and female patients.^{11,23–25,36}

Influence of Gender on Similarities in Preference for Truth-telling

All participants hoped to learn of their medical condition and did not wish the truth to be concealed by doctors or family members. This result is consistent with past studies, suggesting that, when the disease progresses or death is approaching, most patients with cancer hope to be fully told the truth, obtain their prognosis, and be informed of their condition before sharing this information with family members.^{37,38}

For the decision about treatment programs, our study found that both male and female participants hoped that doctors could assist them in making decisions and they preferred to trust their doctors' professional opinion. The current patient-doctor relationship in Taiwan remains a paternalistic model, which results in patients being more likely to transfer the responsibility of decision making directly to doctors.^{36,39} Compared with patients in western societies, the patients in Taiwan have less autonomy.

In terms of truth-telling methods, both male and female participants were more inclined to hope for direct and frank truth-telling without concealment or using euphemisms. This result is consistent with a study in Canada, which found that most patients hoped that doctors would frankly tell them the truth so that they could decide their future plans, bid farewell to others, and maintain their autonomy.⁴⁰ This result is slightly different from past studies, which indicated that eastern society prefers euphemisms, whereas western societies prefer direct truth-telling.^{15,16} In recent years, patients in Taiwan have been able to obtain medical information from diversified sources, so direct and frank truth-telling may enable patients to have more sufficient time to understand the disease and subsequent treatments. Because the participants in this study were all aware of their diagnosis, their acceptance of the disease was higher. Therefore, they preferred direct and frank truth-telling.

Influence of Gender on Differences in Preference for Truth-telling

For the level of truth-telling, this study found that male participants preferred the truth-telling of key points, whereas women preferred detailed truth-telling. Past studies found that female patients' awareness of right-to-know and request for medical quality is significantly higher than for male patients, which may be one of the reasons female patients preferred detailed truth-telling.³⁶

Our findings on truth-telling regarding the survival period are important for understanding what patients in Taiwan hope for and what they obtain. One study determined that 38.3% to 55.6% of family members were told about the patients' survival,⁴¹ whereas most patients were never informed of the survival period and survival rate. Studies in Belgium and Taiwan indicated that 88.2% and 30.2% of patients, respectively, hoped to learn of their life expectancy.^{42,43} These studies did not analyze their data for gender differences. Our study found that most female participants hoped to learn of the survival period, to make arrangements for the future and fulfill their last wishes. Conversely, most male participants did not intend to learn of this, suggesting that learning of it would only increase their psychological pressure, which was not beneficial to their disease. Our findings indicate that additional studies are required to confirm whether gender has an influence on preference for information regarding survival.

One question is whether family members' participation in truth-telling provides support or whether it is a burden to male and female patients. Both SPIKE and SHARE models suggest that, during truth-telling, the participation of family members or significant others can provide patients with emotional support.^{22,44,45} A study in Canada also indicated that patients hoped to be accompanied by family members during communications with doctors and suggested that family members had a significant impact on breaking bad news to dying patients, which could provide patients with spiritual support and reduce emotional stress.⁴⁰ Another study in Iran discovered that 38% of doctors preferred to implement truth-telling when patients were accompanied by their spouse.⁴⁶ However, our study showed that most male participants did not wish to be accompanied by

family members, whereas women did. This finding is consistent with a study in the Middle East, which indicated that most male patients did not hope to be accompanied by family members during truth-telling. However, female patients hoped to be accompanied by at least 1 family member.²³ Moreover, other studies indicated that, when faced with the disease, female patients hoped to obtain more emotional assistance.²⁵ Although studies indicate that family members' participation in truth-telling is desired, there was no examination of gender differences.^{22,40,44–46} Thus, confirmation of our findings will require conducting additional studies regarding gender differences of patients with cancer and family members' participation in truth-telling.

Although gender differences for cancer truth-telling were demonstrated in this study, participants' specific diagnosis and time since diagnosis may have influenced their preferences. Patients' information needs may change during the course of their treatment, and their preferences may be different between those with and without tumor recurrence and metastasis.^{22,47} This study requested participants to recall their experience during truth-telling, which had occurred between 1 and 53 months before participation in our study. Therefore, participants' perception of truth-telling may have been influenced by time. This important factor should be examined in future studies. Truth-telling also has a significant psychological impact on patients, which can influence perceptions of truth-telling, and patients might not fully recall the truth-telling situation. Moreover, to avoid medical conflicts, the regulations of the institutional review board limited requests from physicians at our study sites to patients who were aware of their diagnosis. The preference or opinion for truth-telling of patients who are unaware of their disease may be different, which is the largest limitation of this study.

Studies have indicated that variations in basic characteristics of patients can affect their preference for truth-telling but have seldom analyzed gender differences.^{11,23,40} Our findings show specific gender differences for patients with cancer regarding preferences for truth-telling, which can be provided as a reference for assisting doctors in implementing truth-telling and also for nursing personnel to communicate or interact with patients and family members.

■ Conclusions

Our study showed that female patients in Taiwan preferred to be accompanied by family members and hoped to learn of the survival period and obtain detailed information regarding their diagnosis of cancer. On the contrary, male patients intended less to be accompanied by family members, did not intend to learn of the survival period, and preferred to learn of the key points of truth-telling. There were still some similarities in preference for truth-telling between male and female patients. Both genders hoped to learn of their medical condition and hoped that doctors could directly and frankly tell the truth and could assist in making healthcare decisions. By understanding patients' preferences that differ by gender, medical and nursing personnel could improve sensitivity and quality of truth-telling to better meet the needs of patients with cancer.

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