

Physicians' age and sex influence breaking bad news to elderly cancer patients. Beliefs and practices of 50 Italian oncologists: the G.I.O.Ger study

C. Locatelli^{1*}, P. Piselli², M. Cicerchia¹ and L. Repetto³

¹UOC Oncology, INRCA-IRCCS, Rome, Italy

²Department of Epidemiology, INMI "L. Spallanzani", Rome, Italy

³UOC Oncology, Borea Hospital, Sanremo (IM), Italy

*Correspondence to:

INRCA-IRCCS, UOC Oncology,
Via Cassia 1167, Rome, Lazio,
Italy. E-mail: c.locatelli@inrca.it

Abstract

Purpose: We attempt to shed light on the truth-telling attitudes and practices of oncologists working with a geriatric population in Italy.

Participants and method: Physicians caring for cancer patients were asked to complete a specific survey centred on their beliefs, attitudes and practices towards truth telling to elderly cancer patients.

Results: Of 50 physicians surveyed, 68% were men. Physicians practising in the south of Italy were significantly older and more likely to be of male gender in comparison with physicians practising from the north and central areas. Eighty-four per cent of physicians consider the family to be an obstacle to a direct communication with the elderly. Forty-four per cent of male physicians who are faced with a family's request of nondisclosure talk with the patient, whereas 37.5% of female physicians talk with the family. For 60% of interviewed physicians, the reason underpinning the caregiver's choice of nondisclosure is to delay the emotional confrontation.

Conclusions: We observed that variability of disclosure is related not only to the patient's age but also to the physicians' age and sex and to the geographic area where physicians work. The results also show that both caregivers and physicians are concerned by the emotional aspects related to clinical information. Italian oncologists have to learn and implement 'comprehensive' communication skills and have to promote an integration of the information needs of patient and caregivers, according to their socio-cultural affiliation, within the communication techniques.

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Introduction

The debate on the importance of an effective communication in clinical oncology is a main issue for current biomedical ethics. Few studies, however, have specifically addressed the problem of breaking bad news to the elderly from the physician's perspective.

In the past, the general belief was that bad news was detrimental for the patient and could lead to increased psychological distress, thus supporting the practice of nondisclosure. At the moment, socio-cultural changes in parallel with modern advancements of obtaining medical information through media, web and so on have progressively outdated such a paternalistic approach.

Different studies have highlighted the patients' request towards a more personal approach in understanding their illness as well as the importance of their participating role [1–3]. International literature data show that patient-centred consultation, based on tailored and empathetic communication, lead to improve treatment compliance [4] and patient satisfaction [5], by promoting better awareness of the disease and treatment options [6–9].

Furthermore, despite a global trend towards providing clinical information, numerous reports show relevant cultural differences in truth-telling attitudes and practices in different countries. Cultural differences influence the different roles of family in the information and decision-making

process and affect individual views of the patient–doctor relationship [10–17].

Over the past 10 years, signs of change towards a more open disclosure of the truth telling to cancer patients have been reported in countries, including Italy, previously known to have a paternalistic vision of the patient–doctor relationship and to attribute a protective role to family ties with respect to the ill person [18–22]. Today, more information is given to Italian cancer patients by using the most updated communication tools; informed consent is now a legal and deontological requirement for Italian physicians.

However, there is still consistent data showing the persistent practice of giving patients partial or no information about their illnesses, especially when the patient is elderly [23–26]. The modalities of family involvement are different: in some countries, families are consulted before revealing the diagnosis to patients, and/or they make a decision in place of uninformed patients. [18,27]. This approach can be explained by the central role of a protective behaviour played by the family members. Italy and parts of Asia were among such countries [28–34]. In these countries, there is still a widespread physicians' habit of disclosing cancer diagnosis to the patient's relatives first. For example, Ruhnke *et al.* assessed the perceptions of physicians and patients regarding clinical communication and medical decision making in Japan and the USA and showed that higher proportions of Japanese physicians

(80%) and patients (65%), compared with US physicians (6%) and patients (22%), agreed that a doctor should inform the families first, allowing them to decide whether to inform the patient [24].

The idea that a complete informed consent has not totally evolved in Italy most likely reflects results of a scanty literature. Different studies showed that a large percentage of Italian physicians still do not openly discuss patient prognosis directly to their patients but instead to the family members [23,35,36]. In a recent survey, 87% of physicians first disclosed prognosis to caregivers [37]. We also recently reported similar results from a multi-centric observational study, the G.I.O.Ger study, focused on the patterns of clinical communication in the perspective of elderly patients, caregivers and physicians involved in the cancer care. Results of the interviews administered to patients and caregivers have been published elsewhere [20,23,36,37]. In this paper, we report the results of the 'Survey for health care professionals of oncologic area'. The Survey explored the following areas: psychosocial beliefs, communication attitudes and behaviours towards elderly cancer patients in primary care physicians, operating in different Italian regions. The aim of this study section was to investigate attitudes and behaviours of medical oncologists, radiotherapists and haematologists in their clinical practice towards the issue of clinical communication in elderly cancer patients.

Materials and methods

Participants

To be included in the current study, Italian physicians had to be board certified in medical oncology, radiotherapy or haematology and caring (part-time or full time) for older cancer patients.

Italian cancer care institutions, affiliated to the G.I.O.Ger, were invited to take part in the G.I.O.Ger study on the current patterns of clinical communication in Italy. The Study was fully described by means of brochures regarding the aims of the study as well as technical guidance for the administration of semi-structured interviews, specific for patients and caregivers, and of a Survey, specific for physicians of oncologic areas. Physicians in charge of the participating oncology units were asked to complete a specific survey, 'Survey for health care professionals of oncologic area', concerning their beliefs and practices in clinical communication with older cancer patients.

To be included in the study, patients had to present a diagnosis of solid tumour, be aged 65 years or older, be receiving oncologic treatment (at least three courses) at the time of study interview or completed treatment in the previous month, have a life expectancy of at least 6 months and have a non-professional caregiver who consented to be interviewed and give the consent to participate. Patients with cognitive impairment (minimal state examination ≤ 18) were excluded. Non-professional caregivers were considered the closest and best informed family members assisting and coping with the cancer patient.

Study design and assessment procedure

Forty-seven non-academic Italian hospitals, for a total of 50 oncologic units, were asked to participate to this multi-centric observational study, representative of the Italian situation.

The study was approved by each local ethical committee.

The Survey instrument was developed by the investigators on the basis of published research regarding physician communication with elderly cancer patients [38] and the investigators' prior qualitative work centred on the physician–cancer patient communication [39].

Survey participants were specifically asked to answer questions regarding clinical encounters with their own patients and family caregivers. The Survey instrument included 10 questions, using both quantitative (closed-ended questions) and semi-qualitative (open-ended questions asking for short, hand-written responses) items (Appendix A). The Survey included demographic information about physicians' age, sex, practice environment and estimated number and types of cancer patients seen per month in clinical practice. Quantitative survey items asked participants to choose responses that best described their usual practices (questions 1, 2 and 3). Additionally, participants were queried about potential factors affecting their communication towards elderly cancer patients (questions 4, 5 and 7). Survey questions were printed on a sheet of cardstock and mailed with a cover letter explaining the purpose of the study and how to return the survey. Physicians were invited to complete a survey during the patients' enrolment in the G.I.O.Ger study. Simultaneously, patients and caregivers completed their version of a semi-structured interview on the value and motivation of clinical communication [23,36].

Statistical analysis

Data collected using the paper questionnaire were fed into a specifically developed database. Descriptive statistics are reported as proportions for categorical data or median (and interquartile range) for continuous variables. Chi-square (or Fisher's exact test when applicable) and Mann–Whitney non-parametric tests were used to compare groups for categorical and continuous variables, respectively, and to test their association. Chi-square test for trend was used to test the association of individual item response or characteristics with the geographical area of the clinician considering the gradient north–south.

Data management and statistical analysis were performed using SPSS version 18 (SPSS Inc., Chicago, Illinois).

Results

Physicians' socio-demographic data

All 50 physicians invited to participate in the study completed the Survey.

Demographic characteristics of respondents are listed in Table 1. The median age was 50 years (interquartile range: 41–55); 34 (68%) were men with a median age of 51 years. Male physicians were older than female physicians (men's

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Table 1. Main characteristics of 50 oncologists enrolled in the study according to geographical origin, gender and age

		Total		North		Central		South		p*
		N	%	N	%	N	%	N	%	
Gender	Male	34	<i>68.0</i>	7	<i>58.3</i>	9	<i>50.0</i>	18	<i>90.0</i>	0.053
	Female	16	<i>32.0</i>	5	<i>41.7</i>	9	<i>50.0</i>	2	<i>10.0</i>	
Age (years)	<50	23	<i>46.0</i>	8	<i>66.7</i>	10	<i>55.6</i>	5	<i>25.0</i>	0.010
	50+	27	<i>54.0</i>	4	<i>33.3</i>	8	<i>44.4</i>	15	<i>75.0</i>	
	Total	50		12		18		20		

Only *p* values lower than 0.10 were shown, while *p* < 0.05 were marked in bold.

*Chi-square test for trend.

median age versus women's: 51 vs 43 years, *p*=0.036). The distribution of the Italian geographical area of the participating centres was the following: north (*n*=12, 24%), central (*n*=18) and south Italy (*n*=20). Clinicians operating in the south were significantly older (75% vs 33% were aged 50+ years, *p*=0.03) and more likely to be of male gender (90% vs 58%, *p*=0.036) than their counterparts in the north.

With regard to the workload and patients' typology, physicians declared to be responsible for an average of 50 patients/month where 58% were older patients.

Self-described communication practices

Physicians were asked to describe their usual approach to physician-patient conversation regarding diagnosis and prognosis of illness in older patients.

Results are shown in three different tables according to gender (Table 2), age (Table 3) and geographical area where physicians work (Table 4). Fifty-two per cent of oncologists selecting from a dichotomous option stated that patient's age affected the possibility of a direct communication. Female physicians were more influenced in their practice by patient's age than do male physicians (63% of female physicians versus 47% of male physicians), but this difference was not statistically significant (*p*=0.308; Table 2). Patient's age tended to be a critical factor in regard to clinical communication, especially for female and younger physicians, but even this does not reach statistical significance (Table 3). In addition, with regard to the geographical differences between clinicians from north and south, we found that physicians from the north were more prone to consider age a critical factor towards clinical communication (75% in north, 50% in central and 40% in south Italy, chi-square for trend

Table 2. Responses to Survey for healthcare professionals of oncologic area according to gender

		Total		M		F		p*
		N	%	N	%	N	%	
Item 4	In your opinion, is the possibility of a direct communication with cancer patients correlated with patients' age?							
	No	24	48.0	18	52.9	6	37.5	
	Yes	26	52.0	16	47.1	10	62.5	NS
Item 5**	Which are the main obstacles to a direct communication with an elderly cancer patient?							
	Patient	12	24.0	8	23.5	4	25.0	NS
	Family	42	84.0	27	79.4	15	93.8	NS
	Cultural stereotypes regarding age	13	26.0	9	26.5	4	25.0	NS
	Severity of the disease	7	14.0	5	14.7	2	12.5	NS
Item 6	When a family asked to not disclose the diagnosis to the old patient, what do you usually do?							
	I always treat the family's request	6	12.0	4	11.8	2	12.5	
	I try to explain the consequences of that choice	14	28.0	8	23.5	6	37.5	
	I ask the family information that the patient's will	11	22.0	7	20.6	4	25.0	
	I speak with the patient to understand her or his wishes and awareness of the disease	19	38.0	15	44.1	4	25.0	NS
Item 7**	Which factors induce the family to avoid direct communication between a health professional and an elderly patient?							
	Emotional frailty of an older patient	19	38.0	15	44.1	4	25.0	NS
	Relational difficulties in managing emotional contents of direct communication	19	38.0	12	35.3	7	43.8	NS
	Illusion to contain or delay the emotional confrontation	30	60.0	19	55.9	11	68.8	NS
Item 8	Usually where does the patient receive the communication of the diagnosis?							
	Physician's office	48	96.0	34	100	14	87.5	
	Bedside	2	4.0	0	0.0	2	15.5	NS
Item 9	Request for supplementary psychological support are most frequent from?							
	Informed patient	17	34.0	15	44.1	2	12.5	
	Uninformed patient	11	22.0	7	20.6	4	25.0	
	I do not know	22	44.0	12	35.3	10	62.5	0.077
Item 10	Emotionally, is it easier or more difficult to work with an elderly informed patient?							
	Easier	43	86.0	28	82.4	15	93.8	
	No difference	7	14.0	6	17.6	1	6.3	NS

*Chi-square test (or Fisher's exact test where applicable). Only significant values lower than 0.10 were shown. NS, not statistically significant (*p* > 0.10).

**Items 5 and 7 allowed more than one answer; for this reason, the sum does not add to the total. For these items, each modality was dichotomously considered, and chi-square test was performed.

Table 3. Responses to Survey for healthcare professionals of oncologic area according to age

		Total		<50		50+		p*
		N	%	N	%	N	%	
Item 4	In your opinion, is the possibility of a direct communication with cancer patients correlated with patients' age?							
	No	24	48.0	9	39.1	15	55.6	
	Yes	26	52.0	14	60.9	12	44.4	NS
Item 5**	Which are the main obstacles to a direct communication with an elderly cancer patient?							
	Patient	12	24.0	4	17.4	8	29.6	NS
	Family	42	84.0	22	95.7	20	74.1	0.084
	Cultural stereotypes regarding age	13	26.0	4	17.4	9	33.3	NS
	Severity of the disease	7	14.0	5	21.7	2	7.4	NS
Item 6	When a family asked to not disclose the diagnosis to the old patient, what do you usually do?							
	I always treat the family's request	6	12.0	0	0.0	6	22.2	
	I try to explain the consequences of that choice	14	28.0	7	30.4	7	25.9	
	I ask the family information that the patient's will	11	22.0	7	30.4	4	14.8	
	I speak with the patient to understand her or his wishes and awareness of the disease	19	38.0	9	39.1	10	37.0	0.086
Item 7**	Which factors induce the family to avoid a direct communication between a health professional and an elderly patient?							
	Emotional frailty of older	19	38.0	11	47.8	8	29.6	NS
	Relational difficulties in managing emotional contents of direct communication	19	38.0	12	52.2	7	25.9	0.057
	Illusion to contain or delay the emotional confrontation	30	60.0	11	47.8	19	70.4	NS
Item 8	Usually where does the patient receive the communication of the diagnosis?							
	Physician's office	48	96.0	21	91.3	27	100.0	
	Bedside	2	4.0	2	8.7	0	0.0	NS
Item 9	Request for supplementary psychological support are most frequent from?							
	Informed patient	17	34.0	7	30.4	10	37.0	
	Uninformed patient	11	22.0	5	21.7	6	22.2	
	I do not know	22	44.0	11	47.8	11	40.7	NS
Item 10	Emotionally, is it easier or more difficult to work with an elderly informed patient?							
	Easier	43	86.0	21	91.3	22	81.5	
	No difference	7	14.0	2	8.7	5	18.5	NS

*Chi-square test (or Fisher's exact test where applicable). Only significant values lower than 0.10 were shown. NS, not statistically significant ($p > 0.10$).

**Items 5 and 7 allowed more than one answer; for this reason, the sum does not add to the total. For these items, each modality was dichotomically considered, and chi-square test was performed.

$p = 0.043$; Table 4). Physicians were then asked to select which items could best describe their communication practices with older patients and patient caregivers. When asked about the main obstacles to a direct communication with an elderly cancer patient, 84% of participants indicated patient's relatives, 26% cultural stereotypes regarding age, 24% patients themselves and 14% the severity of prognosis. Thirty-eight per cent of physicians who are facing the family request not to disclose the truth spoke directly with the patient to understand his or her will and awareness of the disease, 28% tried to explain the consequences of nondisclosure to the family members and 22% tried to understand the patient's will through the family. The remaining 12% completely complied with the family request.

In general, male physicians preferred the patient as interlocutor (44.1%), whereas female physicians preferred family members as interlocutors (37.5%; Table 2). We found that the following factors influenced the family request for avoiding a direct patient-physician communication: illusion to contain or delay the emotional comparison (60%), and, similarly, the emotional fragility of older patients (38%) and difficulties in controlling the emotional content of information (38%).

The main setting for a diagnosis communication was the physician's consulting room (96%) and only for 4% at the bedside. As for the existence of a possible association between the level of patients' information and additional request for support, 34% of physicians

considered the informed patient as more demanding, 22% the not the informed patient and 44% did not know. Among this 44%, the most uncertain were women (62.5% vs 35.3%). According to 43 physicians (86%), working with informed patients was easier, whereas the remaining seven physicians did not find any difference.

Discussion

Our study shows that differences in truth-telling attitudes and practices in the information to older cancer patients are related to transcultural factors such as physicians' gender, age and cultural background (as exemplified by the differences between north and south) and also to personal mechanisms in managing emotional aspects.

The families' request to withhold or to mitigate the truth about the cancer diagnosis or prognosis hides not only a protective role in shielding the patient from a severe stress but also an avoidant behaviour of physicians and family members to protect themselves. The results reveal a difficulty, especially for young and female physicians, in dealing with family members of older patients, when the family requests to withhold information from the patient. Requests for nondisclosure are not rare; and, according to McCabe, they cause considerable distress for physicians [40].

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Table 4. Responses to Survey for healthcare professionals of oncologic area according to geographical area

		Total		North		Central		South		p*
		N	%	N	%	N	%	N	%	
Item 4	In your opinion, is the possibility of a direct communication with cancer patients correlated with patients' age?									
	No	24	48.0	3	25.0	9	50.0	12	60.0	0.043
	Yes	26	52.0	9	75.0	9	50.0	8	40.0	
Item 5**	Which are the main obstacles to a direct communication with an elderly cancer patient?									
	Patient	12	24.0	3	25.0	5	27.8	4	20.0	NS
	Family	42	84.0	11	91.7	17	94.4	14	70.0	0.040
	Cultural stereotypes regarding age	13	26.0	3	25.0	2	11.1	8	40.0	NS
	Severity of the disease	7	14.0	3	25.0	1	5.6	3	15.0	NS
Item 6	When a family asked to not disclose the diagnosis to the old patient, what do you usually do?									
	I always treat the family's request	6	12.0	0	0.0	2	11.1	4	20.0	NS
	I try to explain the consequences of that choice	14	28.0	5	41.7	6	33.3	3	15.0	
	I ask the family information that the patient's will	11	22.0	2	16.7	4	22.2	5	25.0	
I speak with the patient to understand her or his wishes and awareness of the disease	19	38.0	5	41.7	6	33.3	8	40.0		
Item 7**	Which factors induce the family to avoid a direct communication between a health professional and an elderly patient?									
	Emotional frailty of older	19	38.0	5	41.7	6	33.3	8	40.0	NS
	Relational difficulties in managing emotional contents of a direct communication	19	38.0	4	33.3	7	38.9	8	40.0	NS
	Illusion to contain or delay the emotional confrontation	30	60.0	8	66.7	9	50.0	13	65.0	NS
Item 8	Usually, where does the patient receive the communication of the diagnosis?									
	Physician's office	48	96.0	11	91.7	17	94.4	20	100.0	NS
	Bedside	2	4.0	1	8.3	1	5.6	0	0.0	
Item 9	Request for supplementary psychological support are most frequent from?									
	Informed patient	17	34.0	3	25.0	5	27.8	9	45.0	NS
	Uninformed patient	11	22.0	4	33.3	4	22.2	3	15.0	
I do not know	22	44.0	5	41.7	9	50.0	8	40.0		
Item 10	Emotionally, is it easier or more difficult to work with an elderly informed patient?									
	Easier	43	86.0	10	83.3	17	94.4	16	80.0	NS
	No difference	7	14.0	2	16.7	1	5.6	4	20.0	

Only *p* values lower than 0.10 were shown, while *p* < 0.05 were marked in bold.

*Chi-square test for trend (north → central → south). Only significant values lower than 0.10 were shown. NS, not statistically significant (*p* > 0.10).

**Items 5 and 7 allowed more than one answer; for this reason, the sum does not add to the total. For these items, each modality was dichotomically considered, and chi-square test was performed.

The variability of truth-telling practices results to be related not only to the patient's age but also to the physicians' sex and age. The high tendency of female physicians to directly interact with the family members rather than with their elderly patient suggests that women may have a different approach not only to the emotional aspects of the disease but also to the importance of family ties as a factor of emotional protection. In the Italian context, the family still plays a significant role at all stages of health care in providing patient assistance, and woman continues to be considered the key person of the family. The finding that younger clinicians also showed a tendency to communicate with the family members may be due to a lack of experience in dealing difficult situations with patients, especially older ones. Sometimes, an interaction where individuals try to protect one another actively hinders disclosure, making it difficult for the physician to communicate in the way he or she considers proper. It is also known that approximately 20% of medical interactions in oncology settings include the presence of a relative and that relatives are more likely to be present when the patient is older and has a poorer performance status [41]. We reported that most of older patients consider their families as the main source of support in dealing with their cancer (86.5%) and ask the caregivers' presence at oncology consultations (79.1%) [23]. The presence of a family member affects contents, quality and duration of physician interactions (interactions with families were

slightly longer, about 3 min, and provide more information) and also patients' behaviours (elderly patients raised fewer issues and were less assertive) [42,43]. In the presence of a third person, where the caregiver seems to take the patient's place, physicians tend to fail using communication skills directed to both patients and relatives. Unfortunately, doctors and nurses approach the patient and the family by using their own experience. Therefore, we need trainings that could form health professionals with the necessary knowledge and technical skills to approach patient together her or his family [44,45]. Physician-patient communication techniques should be included in medical schools training and consolidated by clinical experience. The specific competence of family therapy might be useful to tailor these interventions.

Complex relationships, created by the co-presence of patients and their family, added to a lack of clinical experience, may further explain the greater difficulties of younger physicians. Cultural competency could also contribute to the ability of oncologists to communicate more effectively with their patients, by enhancing an active participation in the cancer care, while respecting cultural and individual differences [10].

Recent studies showed that breaking bad news, especially in palliative care, is often considered by physicians as a strenuous task, potentially compromising their own emotional well-being [46,47]. When doctors withhold a diagnosis from a patient and go along in

concealment of details, they may also try to protect themselves from their own stress or fears, linked to handling the emotional reaction of the patient. The practice of nondisclosure could thus be considered an option easier than open communication. Direct disclosure instead has been shown to reduce anxiety and increase patient satisfaction and treatment adherence when oncologists encourage patients to express emotions [48–51]. Although it is known that mystifying information does not contribute to the possibility of psychological elaboration of denied emotions and it rather could promote their exacerbation, interviewed physicians seem to be afraid of the emotional confrontation with old patients. Feeling of strains in relation to prognostication were found also in an extensive research programme on physicians' health and working conditions carried out in Norway where female physicians found disclosure of prognosis more stressful than do male and the more experienced physicians [52,13].

Regarding this specific issue, in a relatively recent review, Mystakidou *et al.* revealed the need for education in the psychological–emotional aspects of care to help physicians to break bad news, handle emotional crisis and support caregivers [53].

Finally, available data reveal a discrepancy between what Italian physicians stated to believe and what they actually do in their own practices [54,30]. Considering the recent worldwide evolution of truth-telling attitudes among physicians, we observed a significant variability related not only to the physician's age and gender but also to the geographical area where physicians work [23,55–58]. Physicians practising in north Italy inform their cancer patients more frequently compared with their colleagues from the central and south areas, suggesting that regions in the north are closer to the western model, whereas central and south regions still adhere to the ideals of family and traditional values in dealing with a disease [59]. The same results were reported by Baile who underlines major variations among physicians in leading teaching institutions and large city hospitals compared with private and peripheral practices, regardless of the country [25].

In summary, the attitude towards clinical communication in geriatric oncology varies according to the following:

- (i) age and sex of clinicians: younger physicians have more difficulty in managing the relational aspects (caregivers' interference) of the clinical communication, probably due to a lack of experience. Italian female physicians may, instead, have a different approach to patients and their illness, by favouring an integration of social and emotional aspects of the illness and choosing the family caregivers as privileged interlocutors.
- (ii) geographical origin: doctors practicing in the north were less influenced by the presence of the family.
- (iii) specific expertise in communication skills and in the management of emotional aspects. It was observed that communication skills are closely related to the emotional competence of the physician and can influence the quality of clinical communications. Breaking bad news might be perceived by physicians,

especially younger ones, as losing control over their emotions; therefore, they should be more equipped emotionally to manage their own stress.

Our study presents crucial limitations.

First, our data were collected in non-academic centres. The scantiness of information, obtained from the Survey, may be related to the fact that Italian physicians practising in teaching institutions have gained a real interest in the psychological aspects of clinical practice. By contrast, in medical schools and during oncology trainings, there are no specific courses aimed to develop communication skills and related emotional aspects managing ability [60–64]. These important aspects of oncology are becoming more addressed in large cancer centres.

Second, our results describe physicians' self-reports of communication practices, and this may not represent what really occurs in their clinical practice.

Third, our patients were a heterogeneous group because of different tumour types, treatments and prognoses. As clinical communication and its implications vary with prognosis, a future study with a more homogenous sample may yield better findings.

Despite these limitations, our results show the difficulty of Italian oncologists in communicating with elderly cancer patients and in properly dealing with family caregivers' tendency to take control and handle the emotional side of the relationship with elderly patients. Although our data are limited to Italian physicians, the scanty literature on this subject suggests that communication with elderly cancer patients is more difficult and requires the acquisition of specific communication skills. Undoubtedly, there are different barriers to an effective communication ranging from personal attitudes and characteristics of physicians (personal experience, age and gender) to the limitations of the organisational structures where they work. In contemporary societies, oncologists work under increasing economical and time constraints that increase the difficulty to share an appropriate time with the patient. In order to provide appropriate care, culturally sensitive patient information materials need to be produced. Physicians must acquire appropriate skills to communicate sensitively with people, considering cultural, social, religious or regional differences. The acquisition of knowledge and skills in delivering empathetic and culturally sensitive care in the oncology setting became an unquestionable requirement in medical schools [65,66]. Different communication techniques can be developed, considering not only the different needs of elderly patients and caregivers, according to their socio-cultural environment, but also the different attitudes of clinicians towards the social and emotional aspects of clinical communication. Finally, the gap between different geographical areas of the same country must be closed to ensure a uniform medical and psycho-social treatment to all cancer patients, wherever they live.

Italian geriatric oncologists could contribute to research in this field with their specific experience in this population of cancer patients.

Appendix A. Survey for health care professionals of oncologic area

Demographical Data

Name optional:

AGE:

SEX:

PROFESSIONAL QUALIFICATION:

CENTRE:

- 1 In the last month, how many patients were admitted to your center?
- 2 In the last month, how many patients over 65 years were admitted to your center?
- 3 What are the most common oncological diseases in your clinical practice?
 - a. Breast
 - b. Lung
 - c. Colorectal
 - d. Other, specify
- 4 In your experience, the possibility of a direct communication with cancer patients varies according to patients' age?
 - a. Yes
 - b. No
 - c. I don't know
- 5 Which are the main obstacles to a direct communication with an elderly cancer patient?
 - a. Patient
 - b. Family
 - c. Cultural stereotypes regarding the age
 - d. Severity of disease
 - e. Other
- 6 When a family asked to not disclose the diagnosis to the old patient, what do you usually do?
 - a. I always treat the family's request
 - b. I ask the family information than the patient's will
 - c. I try to explain the consequences of that choice
 - d. I speak with the patient to understand wishes and awareness of disease
- 7 Which factors induce the family to avoid a direct patient-physicians communication? (Can contain one or more replies)
 - a. Emotional frailty of older
 - b. Relational difficulties in managing emotional contents of direct communication
 - c. Illusion to contain or delay the emotional confrontation
 - d. I don't know
- 8 Usually where does the patient receive the communication of the diagnosis?
 - a. Physician's office
 - b. Bedside
 - c. Wherever there is available space
 - d. Other
- 9 Request for supplementary psychological support are most frequent from?
 - a. Informed patient
 - b. Not informed patient
 - c. I don't know
- 10 Emotionally, it is easier or more difficult to work with an elderly informed patient?
 - a. Easier
 - b. More difficult
 - c. No difference

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