
REVIEW ARTICLE

Attitudes, beliefs and perceptions regarding truth disclosure of cancer-related information in the Middle East: A review

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(RECEIVED November 28, 2011; ACCEPTED February 26, 2012)

ABSTRACT

The aim of this review is to evaluate the current status concerning attitudes, beliefs and/or practices of patients, family members, health professionals and/or caregivers regarding truth disclosure about a cancer diagnosis in the Greater Middle East countries. A search was done via MedLine for all publications related to this review objective. 55 publications were included emanating from Egypt, Iran, Israel, Jordan, Kuwait, Lebanon, Palestine, Pakistan, Saudi Arabia, Turkey, and United Arab Emirates. In the Greater Middle East region, a diagnosis of cancer is still mixed with social stigma and misperceptions related to incurability. Physicians conserve a truth disclosure policy in which from one side they respect some of the historical and cultural misperceptions about cancer and accordingly, tell the truth about cancer to one of the family members and from another side acknowledge the patients' right to know the truth and tend to disclose it for him(or her) when possible. Family members and caregivers' attitudes, perceptions and beliefs about telling the truth to the patient seem to be in favor of concealment. Discrepant results concerning physicians' and patients' evaluation of the quality of truth disclosure exist in the literature. Education programs in breaking bad news are lacking in many countries. Finally, the most important and common problem affecting truth disclosure to a patient suffering from cancer is the lack of codes and legislations concerning the patients' rights in an informed consent. Studies, legislations and training programs are needed in this domain in Middle Eastern societies.

KEYWORDS: Cancer, Truth disclosure, Attitudes, Beliefs, Middle East

INTRODUCTION

Truth telling about a serious medical condition, such as having cancer, is an important issue in contemporary biomedical ethics that has originated in the United States. Many reports showed that major cross-cultural differences in truth-telling attitudes and practices exist between western and non-western countries (Dalla-Vorgia et al., 1992; Espinosa et al., 1993; Hamadeh & Adib, 1998; Harrison et al., 1997; Pellegrino, 1992; Surbone & Zwitter, 1997; Tanida,

1994; Weil et al., 1994; Williams & Zwitter, 1994). At the beginning of this century, change in attitudes about truth telling has indeed been reported in countries previously known to have policies of non-disclosure (Aoki et al., 1997; Mystadikou et al., 1996; Vincent, 1998; Charniot et al., 2000; Chan & Loth, 2000). In the Middle East, a legitimate conspiracy of silence regarding a cancer diagnosis often takes place with the aim of maintaining the patient's hope. Cancer diagnosis is usually revealed by the doctor only to one or more family members. However, over the past few years, informed consent policies and truth-telling attitudes became applicable in some countries of the Middle East region and truth telling about a cancer diagnosis became the mainstay

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of the contemporary medical practice in some of these countries. The aim of this review is to evaluate the current status concerning attitudes, beliefs and/or practices of patients, family members, health professionals and/or caregivers regarding truth disclosure about a cancer diagnosis in the Middle East countries.

METHODS

A search was done via MedLine concerning truth disclosure about cancer in the Middle East countries. The Middle East countries considered are countries belonging to the Greater Middle East region that includes: Afghanistan, Algeria, Armenia, Azerbaijan, Bahrain, Comoros Islands, Cyprus, Djibouti, Egypt, Eritrea, Georgia, Iran, Iraq, Israel, Jordan, Kazakhstan, Kuwait, Kyrgyzstan, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine (West Bank and Gaza strip), Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tajikistan, Tunisia, Turkey, Turkmenistan, United Arab Emirates, Uzbekistan, Western Sahara, and Yemen. Terms used in the search were: "Cancer" or "serious illness" in association with "disclosure" or "truth telling" or "breaking bad news" and in association with "Middle East" or each considered country name. No language or publication date restrictions were used.

RESULTS

55 publications were considered to describe attitudes, beliefs and/or practices of physicians or health professionals, caregivers, family members or patients concerning the truth disclosure about a cancer diagnosis in these countries. When a study considered these attitudes, beliefs and/or practices concerning cancer diagnosis in a more global perspective such as under the title of a terminal or serious illness, it was also included in the results because of its relevance to the same domain of this study. Every study found to be in the scope of this literature search was included, read and analyzed in order to enhance the power of the review since publications emanating from the Greater Middle East region are not very abundant on the subject rendering, in this perspective, any information useful. Most important findings in these studies will be presented. Some methodological problems could be found in some of these studies such as the low number of subjects included, the sampling procedures, the absence of validity of questioning tools applied, the heterogeneity of subjects included in the samples etc. These methodological problems are not considered to be exclusion criteria of studies because of the need of every available data in the literature on

the subject. However, possibly biased and doubtful results' presentation will be prevented. Findings emanate from Egypt, Iran, Israel Palestine, Jordan, Kuwait, Lebanon, Pakistan, Saudi Arabia, Turkey, and United Arab Emirates. They will be presented according to the alphabetical order of each country name. In every country, data will be presented chronologically in order to demonstrate any progression in perceptions, attitudes or beliefs regarding the truth telling about cancer.

Egypt

Data emanating from Egypt are provided by a single study published in 1997 concerning 100 general surgeons' opinions on telling the truth to their patients who suffer from cancer. Senior surgeons (with more than 20 years of experience) differed from junior surgeons (with less than 10 years of experience) in disclosing more frequently the diagnosis of cancer during the first visit, fully and straightforwardly ($p < 0.001$). The author stressed on the role that the family played, in case of serious illness such as cancer (El-Ghazali et al., 1997).

Iran

In 1997, in a description of the practice of truth disclosure it has been stated that most cancer patients were referred systematically to oncologists without being informed about their cancer diagnosis to avoid facing patient's anxiety and/or fear (Ghavamzadeh & Bahar, 1997). In 2001, a study was conducted in order to investigate cancer patient's education in 167 patients and 143 of their relatives using the Multinational Association of Supportive Care in Cancer's (MASCC) patient education questionnaire. Only 15% of respondents thought that over 80% of patients knew their cancer diagnosis with family and friends communicating the disease diagnosis in 33% of the cases (Montazeri et al., 2002). In 2005, a cross-sectional study investigated the knowledge level of 223 medical students in communication skills through an auto-questionnaire (the communication skills knowledge scale). Analysis of the total scores indicated a mean score of 51.30 that shows that basic knowledge of interns in communication skills is limited. 78.1% of interns had not studied a paper on communication skills (Tavakol et al., 2005). In 2007, an interview prospective study investigated the role of knowledge about the gastro-intestinal cancer diagnosis and compared anxiety and depression in 142 patients who knew (only 48% of the entire sample) or not their cancer diagnosis using the hospital anxiety and depression scale. In the regression analysis, both anxiety and depression showed the strongest association with knowledge of diagnosis

($p = 0.03$ for both anxiety and depression) (Tavoli et al., 2007). In 2008, a study aiming to explore the state of preparation for breaking bad news within medical education was published after interviewing 10 medical course planners. According to this study, doctors majorly delivered bad news in a paternalistic approach. Some of them communicated bad news based on Islamic principles, especially in conveying the difficult news about a patient's impending death (Tavakol et al., 2008). In 2009, data were published concerning the quality of life using the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ-C30) in the same Iranian patients suffering from gastro-intestinal cancer previously described (Aaronson et al., 1993; Tavoli et al., 2007). Comparison of functioning and global quality of life scores between those who knew their diagnosis and those who did not know it, found that those who knew their diagnosis showed a significant lower degree of physical ($p = 0.001$), emotional ($p = 0.014$), and social functioning ($p < 0.001$). Authors suggested that the lower quality of life may not be related to the knowledge of cancer diagnosis and rather it is the physicians' information-giving manner that contributes to such findings (Montazeri et al., 2009). In conclusion, data emanating from Iran show that physicians disclose more frequently a cancer diagnosis to patient's family members than to the patient himself (or herself). The correlation between knowing the diagnosis of cancer and psychological distress could be correlated to insufficiency in communication skills that need improvement especially via medical students' education.

Israel and Palestine

In 1982, a study conducted between 1979 and 1980 aiming to evaluate the psychosocial coping potentials of 86 Israeli patients suffering from cancer revealed that only 19% of patients evaluated had received true information about their cancer diagnosis from their physician (Baider et al., 1982). In 1992, an analysis of patient-doctor relationship was done based on an encounter between 52 patients suffering from cancer and medical staffs in an oncology ward. Patients reported, after the encounter, that they had gained hardly any new information about their illness while doctors were more positive about the processing of the encounter ($p < 0.001$) (Chaitchik et al., 1992). After the instauration of a law, in 1996, mandating informed consent, a study was conducted, in 1997, in order to examine physician's behavior in terms of truth disclosure by evaluating 205 outpatients' and 27 physicians' perceptions. When the actual and ideal physicians were compared in the group of physicians an important level of satis-

faction was found but when this comparison was done in the group of patients, physicians fell short of the ideal on all items ($p < 0.0001$) (Baider et al., 1997). Positive patient-physician relationships were described in another study published in 2000 with the objective of evaluating 103 ambulatory cancer patients' knowledge, expectations, and perceptions. While 92% of patients indicated that they would want disclosure, their high level of satisfaction (85% were very satisfied with the clarity of the information they received) contrasted, in many cases, with the patient understanding of the prevailing disease status (36% of those who had a progressive disease stated that their disease was stable or in remission) (Sapir et al., 2000). A training program for residents in family medicine teaching "how to break bad news" was evaluated in 2002 and 37 family medicine residents reported high level of satisfaction on the module focusing on students' crisis intervention and communication skills (mean score of 4.47 out of 5) (Ungar et al., 2002). In a study published in 2002, 104 elderly patients not having cancer or dementia but who were acutely medically ill inpatients were screened concerning their opinion about the desire to be told one of those diagnoses. 75% wished to be told if they had cancer. Authors stressed on the fact that truth disclosure policy ignores the preference of some patients who do not wish to be told about a cancer diagnosis (Schattner & Tal, 2002). In 2006, a study was published concerning the professional caregiver's response patterns when breaking bad news at the first time of cancer diagnosis and their effect on the patient via a questionnaire administered to 152 patients, nurses, and physicians. Significant differences between patients and professional caregivers were found in the type of information given, in the timing and quantity and in the support and communication patterns ($p < 0.05$) (Rassin et al., 2006). A study published in 2008, aimed to describe 382 family physicians' perceptions, via a questionnaire mailed to them in 2003, regarding the concerns of men with prostate cancer as well as their beliefs and attitudes toward information sharing and decision making with prostate cancer patients. Only 35% of respondents stated that patients should be told the complete truth about their disease and 55% preferred that patients be autonomous in their decision making after they are provided with comprehensive information about treatment options (Cohen Castel et al., 2008). Caregivers' decisions whether to disclose bad news to patients and the difference in decision making in this domain between physicians and nurses were explored, in 2009, in 100 physicians and 200 nurses via two different questionnaires. 63.4% of physicians and only 38.7% of nurses stated that they always disclosed bad news or a

negative prognosis to their patient (Ben Natan et al., 2009). In 2009 a study, in which 103 sixth year medical students presented a test evaluating their personal difficulties and barriers in bad news breaking, was published. Students difficulties were classified into five categories: Emotions and feelings; professional behavior affected by emotions; professional behavior affected by non-emotional issues; long term effects of these problems on professional and personal life; general dilemmas such as ethical issues. Five types of communicators were identified: the distanced; the defensive; the hesitantly courteous; the wholeheartedly involved (Meitar et al., 2009). A recent study aimed to describe 44 urologists' attitudes regarding information sharing with prostate cancer patients using the same questionnaire previously administered to family physicians (Ben Natan et al., 2009). 61% of respondents stated that patients should be told the complete truth about their disease and 96% felt competent at breaking bad news. The comparison between urologist and family physicians attitudes retrieved no difference (Cohen Castel et al., 2011). In conclusion, the Israeli and Palestinian populations are known to be heterogeneous in their ethnic, cultural, and religious background. In these populations, discrepant results are found concerning how patients estimate the patient-physician relationship. Patients may, in occasions, express dissatisfaction concerning their physician's behaviors during truth disclosure of a cancer diagnosis. Although some of non-cancer medically ill patients may desire not to be informed about a cancer diagnosis, physicians seem to fall short on disclosing the full truth to some patients suffering from a progressive disease. Training programs in communication skills seem to be constantly evaluated in order to be ameliorated. Family members seem to be the most important interlocutor when disclosing a cancer diagnosis.

Jordan

Data emanating from Jordan are provided by a single article published in 2009. The study assessed the efficacy of up-front discussion with patients and their families about prognosis and do-not-resuscitate status of 19 children suffering from diffuse pontine glioma. Because do-not-resuscitate discussions were successfully initiated for 11 out of 14 children, authors stated that the Islamic attitudes and beliefs about end-of-life issues should not deter physicians from discussing these matters with the patient's family (Qaddoumi et al., 2009).

Kuwait

A single study emanated from Kuwait in 2002 in which it was stated that there was no legislation or

ethical code, other than Islamic ethics, mandating disclosure of information to patients. Among 217 physicians who were administered an auto-questionnaire regarding their perceptions, attitudes and beliefs about cancer diagnosis and prognosis disclosure, 67.3% tended to tell the truth fully to their patients. "Tellers" considered more frequently that more than 50% of patients in Kuwait want to know their cancer diagnosis ($p < 0.01$). "Non-tellers" considered more frequently that their disclosure policy is influenced by their experience in working in Kuwait ($p < 0.02$) (Qasem et al., 2002).

Lebanon

The Lebanese code of medical ethics, enacted in 1995, did not mandate that physicians should inform patients of their diagnosis but the Lebanese law 574, passed in 2004, stipulated that informed consent must be obtained by a physician prior to any invasive treatment of a patient's condition (Lebanese Code of Medical Ethics, 1995; Republic of Lebanon, 2004). In 1998, a cross-sectional survey regarding truth telling to adult cancer patients was conducted in 1996 on a sample of 212 physicians practicing in Beirut who filled a modified version of a questionnaire used by Novack et al. (1979). Of the sample, only 47% (physicians with longer experience and specialized in any other specialty than primary care) reported that they usually disclose the truth to cancer patients. Patient-related factors (age, degree of intelligence, patient's desire to know the diagnosis, compliance jeopardized) were very important in determining their decision to disclose the truth ($p < 0.05$) (Hamadeh & Adib, 1998). The opinions and expectations regarding disclosure of serious or terminal diagnosis of 498 cancer outpatients, non-cancer patients, and healthy visitors to a medical center were assessed, in 1999, by interviewing them using a slightly modified version of a questionnaire developed by Sardell and Trierweiler (1993). 42% (those who had a younger age, a better education, a tendency to rapport-building with physicians, a cancer diagnosis, were non-Muslim) indicated a preference for nondisclosure of serious or terminal diagnosis. Authors expected that the expectation for concealment will decrease as the advantage of knowledge in better coping with disease is understood by an increasingly better educated public (Adib & Hamadeh, 1999). In 2001, a study evaluated changes of attitude toward cancer disclosure following the introduction of a course on medical ethics in a medical school's education program by interviewing 70 students at four years interval. A large majority (84% in 1995 and 86% in 1998) preferred to disclose the cancer diagnosis to the patient directly (Hamadeh & Adib, 2001).

“Faire Face” group (“let’s face it” group) was founded in 1995 as a voluntary community cancer support group and launched the first in-hospital cancer support in Lebanon in 2003 in response to the fact that quality of life and psychological well being of patients suffering from cancer were more and more recognized as essential outcome care criteria (Doumit, 2011). Professionals’ attitudes and beliefs about palliative care were evaluated, in 2007, via an auto-questionnaire distributed to 1205 nurses and physicians. The majority of nurses and physicians (94% to 99%) believed that terminally ill patients and their families should be informed of the diagnosis and prognosis while only 19% of physicians routinely informed terminally ill patients about their diagnosis and 17.8% of nurses and 8.6% of physicians thought that patients do not have the right to choose “do not resuscitate” (Abu-Saad Huijer et al., 2007). In 2007 and 2008, a study performed in 2005 was published, describing and interpreting, within the Lebanese culture, the communication with cancer patients after interviewing six women and four men suffering from cancer in palliative care. Patients highlighted the importance of communication in the disease trajectory. Patient-family communication and truth telling were reported as major stressors. Patients highlighted the influence of words used during communication and stressed the need to move from the paternalistic approach in care provision to patient-centered care. They clearly accentuated their rights to be told the truth about their condition (Doumit et al., 2007; Doumit & Abu-Saad, 2008). Between 2007 and 2008, a similar study published in 2009, had the same methodology but included 10 participants suffering from breast cancer. For participants, mutual sharing of information was a need. They felt the need to know about their condition from their treating physician and from other women who passed through the same experience. At the same time, they felt the need to share their experiential knowledge with these women (Doumit et al., 2010). In 2010, a study was published concerning an audiovisual package that aims to ameliorate 126 medical students’ communication skills in disclosing bad news. The students reported three barriers to disclose bad news; fear of causing more distress to the patient, family interference, and physician’s uncertainty. Only 14% of the students had the chance to witness a senior physician breaking bad news (Antoun & Saab, 2010). In conclusion, it appears that the truth disclosure practice in the Lebanese society has not been homogeneous during the last two decades. Physicians seem to be reluctant in disclosing a cancer diagnosis to their patients. They frequently discuss the diagnosis with a family member. Patients present some reluctance regarding the receipt of a

cancer diagnosis. Some evidence support the fact that attitudes, perceptions and beliefs from both physicians and patients are constantly prone to change in relation with the changes occurring continuously in the Lebanese society. Medical students’ education programs are trying to follow this change.

Pakistan

In 1997, it was reported that in this country where a majority of Muslims live, there was a lack of general awareness about cancer and the diagnosis was often hidden from the patient by the family members who feel that it will be psychologically detrimental to the patient and will worsen the quality of life (Malik & Qureshi, 1997). In 2004, a study was published, aiming to evaluate, via a questionnaire, the views of 70 physicians from different specialties working in university hospitals on their understanding of palliative care in general. 60% thought that the bad news was conveyed appropriately (Abbas et al., 2004). In 2010, a study conducted in 2008 was published with the aim of exploring, via a questionnaire, 400 medically ill subjects’ expectations and perceptions from their physicians when they disclosed bad news to them. Diagnosis of cancer or its recurrence has been stated as the most likely example of bad news (35.5%). Only 11% of respondents wished they never knew the bad news while up to 52% of respondents wished to know the complete details of the bad news (Ishaque et al., 2010). In 2010, a qualitative study evaluating the lived experience of 36 Muslim Pakistani out-patient women suffering from breast cancer in the United Kingdom and in Pakistan was published. A significant result concerned the reaction of fear, threat and sadness felt after the discovery of cancer followed by a period of decisiveness to seek medical treatment. Unfortunately, not all family reactions to the bad news were supportive. Irrespective to the city of residency, the social stigma attached to a cancer diagnosis in the Pakistani society seemed to have an important influence on women’s psychological well-being (Banning et al., 2010). In conclusion, despite some evidence that the general opinion is in favor of being told a cancer diagnosis in Pakistan, the general medical practice still involve, in the truth telling activity, the patient’s family more than the patient himself (or herself). Social stigma about having a cancer appears to be another worsening feature of the situation.

Saudi Arabia

In 1991, a study assessing 600 adults’ knowledge, perceptions and attitude about cancer in Saudi Arabia showed that the level of misperceptions was highly independent of the subjects’ level of education

(Ibrahim et al., 1991). In this Saudi Arabian conservative Islamic society where policies regarding truth disclosure lacked, a report published in 1997 stated that, the patient's treatment was given by the family in order to avoid disturbing the patient emotionally (Mobeireek et al., 1996). In 1997, a study conducted in 1993 by administering an auto-questionnaire to 249 senior and junior physicians in the purpose of evaluating their attitudes and practices toward communicating a serious illness, was published. Only 47% of physicians reported that they provided information on the diagnosis and prognosis of a serious disease and 75% of physicians preferred to talk with close family members even when dealing with competent patient (Younge et al., 1997). 321 physicians' and 264 in- and out-patients' attitudes toward the process of diagnosis disclosure and decision making were evaluated via an auto-questionnaire in a study published in 2008. 67% of physicians gave the patient the authority to decide whether the family should be informed and most patients preferred a family centered model of care. Views toward truth disclosure were found to be midway between those of the United States and Japan (Mobeireek et al., 2008). In 2009, a study done between 2002 and 2005 was published aiming, via a structured interview, to assess the attitudes of 114 patients suffering from cancer toward disclosure of cancer diagnosis and prognosis. 113 patients wanted to get full information while only one wanted to have partial information. All patients wanted to know about their prognosis (Al-Amri AM, 2009). In 2010, it has been stated that attitudes toward truth disclosure to patients suffering from cancer are undergoing slow but steady changes due to public education and partial cultural openness (Aljubran, 2010). Between 2009 and 2011, 402 mothers were enrolled in a study in order to determine their preferences in receiving bad news in case their child was attained of a serious disease. Results showed that they preferred that braking bad news be conducted with both parents together (64%), early after the confirmation of the diagnosis (79%), in detail (81%), in person (88%) and in a quiet setting (86%) (Al-Abdi et al., 2011). In 2011, a study was published evaluating 332 medical students, attending oncology lectures between 2003 and 2008, toward the disclosure of information in case they suffered from cancer. 92.8% of them stated that they would like to know about diagnosis of cancer with differences related student's region (more students from the Eastern region wanted to be disclosed a cancer diagnosis; $p = 0.01$) (Al-Amri, 2011). In conclusion, despite the appearance of solid data confirming that the general population preferences concerning truth disclosure about cancer in Saudi Arabia are in favor of being told the truth in person,

changes in attitudes of physicians about truth telling, although noticeable in the last decade, are still incomplete. Education programs for medical students lack assessment in the field of bad news' communication skills.

Turkey

In 1993, 45 cancer patients receiving chemotherapy in a chemotherapy day clinic were interviewed about the level of their awareness of disease and treatment, prognosis, the sources of information, and whether these affected their satisfaction with the services given. No significant differences were found between groups of different educational levels in awareness of disease or in patient satisfaction with the available medical services (Derman & Serbest, 1993). Patient-physician communication quality was assessed, in 1997, in 108 patients treated at a radiation oncology department via an auto-questionnaire. 88% of included patients were informed about their diagnosis and 63% were satisfied with the given information. High-educational level patients and women were informed more often than others ($p < 0.05$) (Sen, 1997). In 2002, a study accomplished in 2000 was published, including 100 in- and out-patients suffering from cancer who were interviewed in order to determine their perceptions of the truth telling practice and to assess their quality of life using the EORTC QLQ-C30 (Aaronson et al., 1993). 44% of the patients did not know their diagnosis. There was no significant difference between the scores on any of the scales of EORTC QLQ-C30 regarding diagnosis' awareness (Bozcuk et al., 2002). In 2003, a study conducted between 2000 and 2002 was published having the purpose of evaluating factors associated with psychiatric morbidity in 150 in- and out-patients suffering from cancer. 54% of patients did not have any information about their diagnosis. 28.7% of cancer patients were found to have a DSM-IV Axis I diagnosis (adjustment and mood disorders). Knowing the diagnosis of cancer showed a positive correlation with anxiety and depression scores ($p = 0.001$) (Ateşci et al., 2003). Another study conducted in the same period with the same objectives and methodology published one year later included 131 hospitalized patients suffering from cancer. 54.7% were unaware of the cancer diagnosis. 30% suffered from psychiatric disorders, with a higher prevalence in patients who were aware of their diagnosis ($p = 0.03$). Authors supposed that the high prevalence of psychiatric disorders among the aware patients may be related to having inadequate information (Ateşci et al., 2004). In 2004 also, a study concerning 150 out-patients' relatives attitudes toward informing patient, was published. Of these relatives, 66% did not want the diagnosis

to be disclosed. In the multivariate analysis, the diagnosis of a non-breast cancer malignancy, and insufficient knowledge of relatives about cancer were significantly associated with a relative's attitude in favor of concealment ($p = 0.0001$ and $p = 0.01$, respectively) (Ozdogan et al., 2004). Another study conducted between 2004 and 2005 and published in 2006 evaluated, via an auto-questionnaire, the attitudes and beliefs of 270 accompanying persons for out-patients receiving chemotherapy. Only 48.2% gave the opinion that the patient should be informed correctly regarding the diagnosis (Oksüzöglü et al., 2006). In 2006, a study conducted in 2003 was published concerning 131 physicians' attitudes and factors determining truth telling via an auto-questionnaire modified from another questionnaire developed by Oken et al. (1961). The percentages that never, rarely, generally, and always tell the truth about diagnosis were 9%, 39%, 45%, and 7%, respectively. In the multivariate analysis, "do not tell" requests from relatives and previous training in breaking bad news were found significant ($p = 0.025$ and $p = 0.017$, respectively) (Ozdogan et al., 2006). In a study published in 2008 and conducted between 2005 and 2006, feeling and thoughts at the time of diagnosis of 34 free of disease patients suffering from head and neck cancers were retrospectively evaluated via an auto-questionnaire. 32 patients were announced the diagnosis by their physician and 47% of them expressed their wish for a more friendly and affectionate communication (Yildirim & Erişen, 2008). In a study conducted in 2005 and published in 2008, attitudes and beliefs regarding patient's rights to information and autonomy, of 204 patients suffering from cancer and attending an out-patient clinic, were evaluated using a semi-structured interview. 86.5% agreed on the statement that the patient has the right to receive information about the diagnosis and the treatment and 92.3% stated that the physician should inform the patient about these issues (Erer et al., 2008). In 2010, a study evaluated the effect of illness representation, perceived quality of information delivered by the health-care professionals, perceived social support and depression in 71 caregivers of children suffering from leukemia using tests such as the Illness Representation Scale and the Multidimensional Scale of Perceived Social Support and Beck Depression Inventory (Beck et al., 1961; Prohaska et al., 1985; Zimet et al., 1990). Illness representation was significantly related to the level of caregivers' depressive symptoms ($r = 0.47$; $p < 0.01$). Moreover, the quality of information provided by the health care professional and perceived social support were positively related ($r = 0.33$; $p < 0.01$) indicating that the higher the quality of information provided by the health care

professional, the higher the social support perceived by the caregivers (Bozo et al., 2010). In an overview published in 2010 concerning truth telling in health care system, it has been concluded that the situation suggests that truthful disclosure to cancer patients is not a common procedure in clinical practice despite the serious potential ethical problems associated with such an approach (Güven, 2010). In conclusion, Turkey is a country where the cultural aspects of the society are impinged by the Eastern societies' norms and where the Western and European legislative norms are frequently applied. Turkish patients suffering from cancer clearly express their desire of being told about a cancer diagnosis and prognosis. They don't deny the importance of family support during this process. Conversely, caregivers do not unanimously respect the patients' right of being told the truth about cancer. Physicians' attitude in this domain tends to respect the patients' right to know the truth but is limited by a certain deficit in truth disclosure' education programs from one side and the family pressure from another side. The higher incidence of psychiatric morbidity in patients aware of their diagnosis could be related to this deficit in physicians' communication skills.

United Arab Emirates

A single study emanating from the United Arab Emirates has been published in 1997. The researchers' purpose was to elucidate the attitudes and beliefs of 100 healthy Emiratis and 50 physicians concerning truth telling to patients suffering from cancer. When comparing both groups fewer physicians believed that patients should be informed that they will die in the next six months (8% vs. 27%; $p < 0.01$) even when the patient asked (42% vs. 59%; $p < 0.001$). The same results were almost replicated in the case of a patient who have a 50% risk of dying during the next six months (0% vs. 30%; $p < 0.0001$ will tell even if the patient asked 28% vs. 59%; $p < 0.001$). 71% of selected Emiratis and 88% of physicians thought that it is justified for the physician to tell the truth to the family instead of the patient (1997).

DISCUSSION

Attitudes, perceptions, and beliefs about truth telling regarding a cancer diagnosis or prognosis seem to be very controversial in the Greater Middle East region. In this area of the world, a vast majority of Muslims live. Religiosity is one of the prominent features of daily life. In addition, the social structure is based on the importance of the family bonds instead of the individual autonomy. A diagnosis of cancer is, in many countries of the Greater Middle East, still

accompanied with social stigma and misperceptions related to incurability. The majority of these countries did not invest in the elucidation of their population's attitudes toward truth telling to a patient suffering from cancer. Physicians, although frequently trained in Western countries, conserve a truth disclosure policy that respects some of the historical and cultural misperceptions about cancer. They frequently tell the truth about cancer to one of the family members and try to conceal it from the concerned patient. However, a majority of them acknowledge the patients' right to know the truth. A trend, during the last decade, toward an increase in the proportion of truth telling to patients suffering from cancer seems to be deductible from the literature. Family members and caregivers' attitudes, perceptions, and beliefs about telling the truth to the patient are not very well studied, but seem to be in favor of concealment. The most important explanation factor is the conservation of the patient's psychological well-being. In fact, some evidence support the assumption that patients aware of the diagnosis of cancer are more prone to express psychological distress and develop psychiatric morbidities. Before any jumping to conclusions in this domain, the quality of patient-physician communication quality should be evaluated since how the truth was disclosed is as important as the truth itself. Discrepant results concerning physicians' and patients' evaluation of the quality of truth disclosure exist in the literature. However, truth communication quality is partially reflected by the presence and the quality of education programs in breaking bad news taking place in medical schools. These programs are lacking in many countries in the Greater Middle East (except, for example in countries like Iran, Israel, and Lebanon). In addition, the implication of other health care professionals, such as nurses in the truth telling activity may contribute in accelerating the change in attitudes, perceptions and beliefs. Finally, the most important and common problem affecting truth disclosure to a patient suffering from cancer is the lack of codes and legislations concerning the patients' rights to obtain an informed consent or even the lack of their application wherever they were present. The presence of a cultural incompatibility with the Western codes, legislations and principles does not, in any way, justify the absence of Middle Eastern codes, legislations and principles that obliges physicians to apply their own judgment to decide about the strategy they have to adapt in terms of disclosing the truth about cancer.

There are some limitations to this literature review. As mentioned above, a more restrictive selection of studies to those that are methodologically well-performed might be preferred but it could have

lowered the number of studies included to half of what it is actually. More importantly, data emanating from some countries might be completely occulted which eliminates the possibility of having an idea on the subject of attitudes and beliefs regarding truth disclosure about cancer in these countries. Another limitation is related to the source of information consulted providing that many studies done in the Middle Eastern countries are not available via MedLine but could be found for example in the grey literature.

CONCLUSION

Truth disclosure about cancer still constitutes a subject of controversies in the Middle East region. Despite the fact that there has been a change in attitudes, perceptions of beliefs about this subject among the general population, patients suffering from cancer, their families and health professionals, truth disclosure is still far from being systematic, standard and legislated. Studies, legislations and training programs are more and more required in this domain.

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