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A Study on the Attitudes of Physicians: Approach Towards Death and Terminally ill

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ABSTRACT

A study on the attitudes of physicians: approach towards death and terminally ill

Objective: The aim of this study was to investigate primarily, the attitudes of physicians toward death and terminally ill patients and, secondly, the relationship between the sociodemographic variables of the physicians and these attitudes. Also, this study aimed to find out the relationship between the death anxiety of the physicians and their avoidance behavior of informing patients about their diagnoses. Lastly, the physicians were asked about the necessity of education on how to approach patients with terminal ilness.

Methods: The study subjects were 304 physicians. A questionnaire about sociodemographic information, the Death Anxiety Scale and a 15 item questionnaire prepared by the authors to evaluate the attitudes of physicians were applied to the participants.

Results: 89.1% of the physicians believed that patients had the right to be informed of their diagnoses, independent of what the diagnoses were. However, when the diagnosis was a terminal illness, only 78.3% of the physicians accepted that the diagnosis should be announced. In addition, when the terminal disease was cancer, 77.6% of the physicians agreed that the patient should be informed about the diagnosis if the patient was the physician him or herself. This ratio was 55.6% when the patient was a physician's relative and 51% when the patient was an unrelated adult. 94.4 % of the physicians (n= 287) agreed that education on how to approach death and terminally ill patients should be given during or after the medical education. The responses to the questionnaire were found to differ according to variables of death anxiety, practice area, gender and having children or not.

Conclusion: This study explored the difficulties of the physicians when approaching death and the terminally ill, which is a neglected but important area in medical practice. This study examined and stated out these difficulties for further discussion.

Key words: Death, anxiety, physician, cancer

ÖZET

Hekim tutumları üzerine bir çalışma: Ölüm ve ölümcül hastaya yaklaşım

Amaç: Bu çalışmada, hekimlerin ölüm ve ölümcül hastaya ilişkin tutumları, hekimlerin sosyodemografik özelliklerinin ölüm ve ölümcül hastaya yaklaşımları üzerine etkisi, ölümcül hastalık tanısını söylemekten kaçınma davranışının hekimin kendi ölüm kaygısı ile ilişkisi ve hekimlerin bu konuyla ilgili eğitimin gerekliliği hakkındaki görüşlerinin araştırılması amaçlanmıştır.

Yöntem: Çalışmaya 304 hekim alınmış ve kendilerine sosyodemografik veri formu, ölüm ve ölümcül hastaya yönelik hekim tutumlarını değerlendirmek amacıyla yazarlar tarafından geliştirilen 15 soruluk bir anket formu ve Ölüm Kaygısı Ölçeği uygulanmıştır.

Bulgular: Hekimlerin %89.1'i hastaların, tanıları her ne olursa olsun bilgilenme hakları olduğuna inanmakla birlikte, söz konusu hastalık "ölümcül" olduğunda, %78.3'ü tanının hastaya söylenmesi gerektiğini kabul etmektedir. Ölümcül hastalık 'kanser' olduğunda ise, hekimlerin tanının açıkça söylenmesi fikrine katılma oranları; kendisi söz konusu olduğunda %77.6 oranındayken, bir yakını söz konusu olduğunda %55.6, herhangi erişkin bir hasta söz konusu olduğunda ise %51 olmaktadır. "Tıp eğitimi sırasında veya sonrasında, ölüm ve ölümcül hastaya yaklaşım hakkında bir eğitim gereklidir." ifadesine hekimlerin %94.4'ü (n=287) katılmıştır. Anket sorularına verilen cevaplarda cinsiyet, çocuk sahibi olma, çalışma alanı, ölüm kaygısı düzeyine bağlı olarak farklılıklar olduğu saptanmıştır.

Sonuç: Bu araştırma, hekimlik mesleği uygulamaları içinde önemi ihmal edildiği düşünülen bir alan olan, ölümcül hasta ve ölüme yaklaşımda yaşanan zorlukları bir ölçüde saptayıp tartışılır hale getirecek veriler ortaya koymuştur.

Anahtar kelimeler: Ölüm, kaygı, hekim, kanser

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INTRODUCTION

Duration of living with chronic diseases, proportion of admissions to physicians in case of illness and rates of inpatient deaths among all deaths are increasing worldwide due to advancement of medical care and conditions of living. Physicians encounter with fatal diseases more frequently and treatment period of these patients increase due to these factors (1). However, during medical education, basic issue taught about

death and fatal diseases was its diagnosis and treatment. Dying patients and their attitudes toward death were not adequately considered during medical education (2). Research about this topic showed that final year medical students who were about to enter medical profession felt themselves incapacitated, unprepared, empty, angry and unsuccessful when encountered with dying patients (1) and some physicians who encounter with the same situation felt themselves guilty as if they were responsible from patient's condition (3).

Akça and Köse reported that death was characterized as a taboo both by behavioral scientists and health professionals in 1960s when Templer started to work on death anxiety and told that this gap directed him towards developing "Death Anxiety Scale" (4). It was proposed that physicians have higher death anxiety than other professionals and even become physicians to overcome this anxiety. Although they are familiar with these issues, being exposed to illnesses and death for a long period of time may arise death anxiety as well (5).

Medical ethics which is increasingly having more importance stresses on patient's right of self-determination in context of confidence which correct information about disease and options are given in patient-physician relationship (6). Every patient has the right to learn his/her disease and also has the "right of being informed" about possible causes of disease, expected disease processes and possible risks and benefits of the treatment. Right of being informed was defined under topic of right of self-determination in World Union of Physicians, Bali Declaration of Patients' Rights (7). It is believed that explaining diagnosis of a fatal disease to the patient is a condition which is quite stressful but can be learned as well. Best way of learning is learning by observation and being observed in order to get feedback subsequently (8). Studies proposed that patients can cope with fatal diseases more efficiently by the support of physician interaction. Risk of developing a psychiatric disorder increases when patients cannot access correct information or when their emotional responses are not taken into consideration (9).

Studies done in the last forty years showed that there are cultural differences in telling the truth to the patient. In many countries family is the most powerful support system of the patient and often tries to protect the patient from harm. For this reason, it was reported that they don't want the diagnosis to be told to the patient as well (10). This attitude is mainly preferred in family-centered cultures. It was also reported that patients from this culture want their relatives with them more than patients from Western cultures and do not prefer to discuss their life expectancies (11).

When studies done in Turkey on this subject are searched, it can be seen that studies evaluating the approaches and attitudes to death and dying patients during nursing services make up the majority of them (12-14). Although there are scientific reviews about the correct physician attitude towards death and dying patients (3,15-17), no comprehensive study investigating physicians' attitudes and factors affecting them is available. In an era of developing guidelines for giving unpleasant news in many countries, there are few data about physicians' attitudes and expectations of patients from physicians. Before determining the method on this issue in our country, more data have to be cumulated. For this reason, in this study, we aimed to investigate the attitudes of physicians working in Eskişehir Osmangazi University Medical School Hospital towards death and dying patients, effect of socio-demographic characteristics of physicians on their attitudes towards death and dying patients, relationship between avoiding to tell diagnosis of fatal disease and death anxiety of the physician and opinions of physicians about the need on this issue.

METHODS

For this study, 355 physicians who are currently working at Eskişehir Osmangazi University Medical School Hospital were accessed. Physicians were visited at their departments and information about the study was given and data were collected by fulfilling the questionnaire and returning them back. It was mentioned in the form to the participants that ethical council approval was taken and voluntary participation without declaring names was needed. Fifty-one forms which were filled randomly or left empty were excluded

and study was conducted over data filled by 304 physicians.

A socio-demographic data form to determine socio-demographic characteristics, a questionnaire containing 15 questions which was developed by authors to evaluate attitudes of physicians towards death and dying patients and Death Anxiety Scale were applied to the physicians participated in the study.

Questionnaire Form: This questionnaire was developed based on basic textbooks on psychiatry and ethics (1,6) and studies on this subject (15,16,18-21) and was designed to tick "Agree", "Disagree" or "Undecided" choices. Questionnaire form consisted of questions assessing need for education on medical ethics and death, thoughts about dying patients, opinions and attitudes about concept of "good death" and its availability, physician's own mental state when encountered with patients having fatal disease and their attitudes towards patients. At the end of the questionnaire, their opinions about telling the diagnosis when one of their relatives or one of their patients were diagnosed "cancer" were asked and required to tick as "agree" or "disagree".

Death Anxiety Scale: This scale was developed by Templer (22) and its validity and reliability study was done (4). The scale consists of 15 items and each item is assessed by choosing "Yes" or "No" choices. If the total score obtained from the scale is 8 or over, this points out the presence of death anxiety.

Statistical Evaluation: All data analyses were performed by SPSS 15.0 package software. Continuous quantitative data were expressed as n, mean and standard deviation; qualitative data were expressed as n and proportion. Independent data sets which did not show normal distribution and consisted of score variables were analyzed by Mann-Whitney U test. Categorical data sets were analyzed by Chi-square test. Two Proportions test was used when determining the differences between cells in cross tables. Differences between opinions of physicians about telling the diagnosis when cancer was diagnosed at himself, one of his/her relative or an adult were assessed by Proportions Test by Minitab 15 software. $p<0.05$ was taken for statistical significance.

RESULTS

Mean age of the study group (n=304) was 33.6±8.91 (between 24-65 years) and 47% were women and 53% were men. 55.6% of the study group was married, 41.8% was single and 2.6% were divorced/widowed, 33.9% had children and 66.1% did not have. Mean duration of professional practice of physicians participated in the study was 8.6 ± 8.59 years (between 1-42 years). 72.7% of the physicians were residents, 27.3% were specialists or academics. Distribution of the physicians regarding their specialties were as follows: 138 were from medical (45.4%), 125 were from surgical (41.1%), 41 were from basic medical sciences and radiology (13.5%). 60.5% of the study group did not take any training regarding death and approach to dying patient while 39.5% did. Among ones who stated that they took a kind of training, 29.6% of them took it during medical education, 8.6% took after medical education by courses and seminars etc. and 2.6% took by other means (Table 1).

Table 1: Socio-demographic characteristics of participating physicians (n=304)

Age (Mean±S.D.)	33.6±8.91 (24-65 years)
Feature	**n (%)**
Gender	
Women	144 (47%)
Men	160 (53%)
Marital Status	
Married	169 (55.6%)
Single	127 (41.8%)
Divorced/widow:	8 (2.6%)
Children	
Yes	103 (33,9%)
No	201 (66.1%)
Duration of practice	8.6 ±8.59 (1-42 years)
Professional title	
Resident	221 (72.7%)
Specialist/Academician	83 (27.3%)
Specialty	
Internal Medicine	138 (45.4%)
Surgery	125 (41.1%)
Basic Science/Radiology	41 (13.5%)
Training about death and approach to dying patient	
Received training	120 (39.5%)
During medical education	90 (29.6%)
After medical education by courses etc.	26 (8.6%)
By other means	4 (2.6%)
Not received training	184 (60.5%)

When responses of physicians to the questionnaire were evaluated, 97% of the group agreed with the statement "Patients who learned that they have a fatal disease pass through psychological stages which cause them to give different responses to their environment and the treatment team". According to ones who agreed this statement, factors responsible for these different psychological responses were as follows according to degree of importance: Personality characteristics of the patient (41.3%), education/socio-cultural level of the patient (33.5%), age of the patient (15.2%), religious beliefs of the patient (6.1%), content of the relationship between patient and treatment team (3.7%). 94.4% of physicians agreed with the statement "Training about death and approach to dying patient is needed during or after medical education". While 93.8% of the physicians agreed with the statement "Professional help is needed in difficult situations regarding patients-physician relationship when approaching to death and dying patient", 87.3% reported that "they will forward the patient for the help of psychiatrist/psychologist" for professional help, 7% reported that "they will receive consultancy of professional help for themselves", 4.9% reported that "they will think about getting religious help", 0.7% reported that "they will direct patients towards another physician who will maintain his/her treatment". "A patient has the right to learn about treatment options, prognosis and reject treatment whatever his/her diagnosis is" statement was agreed by 89.1% of the physicians and 88.2% agreed with the statement "I will have emotional difficulty when telling the fatal disease or death". Emotional difficulties which physicians experienced towards death and fatal conditions were found to be sadness (71%), desperation (48%), distress-anxiety (42%), feeling of emptiness-meaninglessness (31%), examining his/her profession (24%) and feeling of inadequacy-guilt (21%). 79.3% of the physicians agreed with the statement "Patients with

Table 2: Results of the questionnaire implemented to 304 physicians participated in the study

	Agree		Disagree		Undecided	
	n	(%)	n	(%)	n	(%)
1. A patient has the right to learn about treatment options, prognosis and reject treatment whatever his/her diagnosis is.	271	89.1	11	3.6	22	7.2
2. All good and bad information about the diagnosis and treatment should be told to a patient with a fatal disease.	234	78.3	24	7.9	46	15.1
3. When telling the diagnosis and treatment to a patient with a fatal disease, his/her life span should not be told exactly.	238	78.3	32	10.5	34	11.2
4. Telling a fatal disease diagnosis openly does not negatively affect patient's prognosis and emotional state.	85	28.0	161	53.0	58	19.1
5. Patients who know their fatal disease want to talk about their conditions and death.	95	31.3	125	41.1	84	27.6
6. Patients with a fatal disease are aware of the situation even their diagnoses were not told to them.	217	71.4	41	13.5	46	15.1
7. I find it difficult to encounter with a patient who has a fatal disease or his/her relatives compared to other patients and their relatives.	241	79.3	56	18.4	7	2.3
8. I avoid to tell patients directly that they are dying.	217	71.4	56	18.4	42	13.8
9. I find it emotionally difficult when telling a fatal disease or death.	268	88.2	25	8.2	11	3.6
10. Training about death and approach to dying patient is needed during or after medical education.	287	94.4	9	3.0	8	2.6
11. Professional help is needed in difficult situations regarding patient-physician relationship when approaching to death and dying patient.	285	93.8	13	4.3	6	2.0
12. Patients who learned that they have a fatal disease pass through psychological stages (denial, anger, depression, acceptance etc.) which cause them to give different responses to their environment and the treatment team".	295	97.0	3	1.0	6	2.0
13. Whatever the diagnosis and prognosis of the disease is, good death and providing it by health professionals is possible.	213	70.1	34	11.2	57	18.8
14. If I was the patient, I would have preferred to be told whatever the diagnosis and prognosis is	236	77.6	23	7.6	45	14.8
15. If the patient was my relative, I want the diagnosis and prognosis to be told whatever it was	203	66.8	43	14.1	58	19.1

a fatal disease are aware of the situation even their diagnoses were not told to them" and 71.4% agreed with the statement "I find it difficult to encounter with a patient who has a fatal disease or his/her relatives compared to other patients and their relatives" and 78.3% agreed with the statements "When telling the diagnosis and treatment to a patient with a fatal disease, his/her life span should not be told exactly" and "All good and bad information about the diagnosis and treatment should be told to a patient with a fatal disease". Among physicians who agreed that it is necessary to tell all good and bad information about the diagnosis and treatment to the patient with a fatal disease, 12.5% found it appropriate to tell this information to the patient itself first, 29.6% thought that it should be told to the patient's family, 5.3% thought that it should be told to the patient if his/her family gives permission to do so and 33.2% told that it depends on the patient. Twenty-four physicians who did not agree with the need to tell all good and bad information to the patient reported their reasons as fear of not controlling emotional reactions (58.3%), emotional difficulty (12.5%), not knowing how to tell (4.1%), fear of being blamed (4.1%) and 20.8% did not give any response. 77.6% of the physicians agreed with the statement "If I were the patient, I would like to be told what the disease or prognosis was", 71.4% of the physicians agreed with the statement "I will avoid telling patients directly that they are dying", 70.1% of the physicians agreed with the statement "Whatever the diagnosis and prognosis of the disease is, good death and providing it by health professionals is possible", 66.8% of the physicians agreed with the statement "If the patient was my relative, I want the diagnosis and prognosis to be told whatever it was". Only 31.3% agreed with the statement "Patients who know their fatal disease will want to talk about their conditions and death" and only 28% of the physicians agreed with the statement "I think that telling the diagnosis of a fatal disease openly does not negatively affect patient's prognosis and emotional state" (Table 2).

Responses to questionnaire were evaluated regarding age, marital status, professional title, number of children, specialty, death anxiety and no significant difference was found for age, marital status and professional title. In the evaluation regarding gender, "All good and bad information should be told to the patient with a fatal disease about its diagnosis and treatment" statement were disagreed by 6.2% of male and 9.3% of female physicians at question #2 and "disagree" response was significantly higher in female physicians compared to male physicians ($p<0.05$). Among physicians having children, 73.7% agreed, 4.8% disagreed and 21.5% were ambivalent to the question #2; among physicians who did not have any child, 78.6% agreed, 9.4% disagreed and 12 % were ambivalent. Agreement rates between physicians having and not having children were significantly different for question #2. ($\chi^2=5.985$, SD=2, $p<0.05$). At question #6, agreement with the statement "I think that patients with a fatal disease are aware of their conditions even their diagnoses were not told to them" was significantly higher in physicians

Table 3: Questionnaire items found significantly different when compared according to have child or not.

		Having Children		Not Having Children	
		n	(%)	n	(%)
2.	All good and bad information about the diagnosis and treatment should be told to a patient with a fatal disease*				
	Agree	76	73.7	158	78.6
	Disagree	5	4.8	19	9.4
	Undecided	22	21.5	24	12.0
6.	Patients with a fatal disease are aware of the situation even their diagnoses were not told to them**				
	Agree	84	81.5	133	66.1
	Disagree	5	4.8	36	17.9
	Undecided	14	13.5	32	15.9

* statistical significance; $p<0.05$
** statistical significance; $p<0.01$

Table 4: Questionnaire items found significantly different when compared according to death anxiety levels.

		Low Level of Death Anxiety		High Level of Death Anxiety	
		n	(%)	n	(%)
4. Telling a fatal disease diagnosis openly does not negatively affect patient's prognosis and emotional state**					
	Agree	59	36.1	26	18.4
	Disagree	74	45.3	87	61.7
	Undecided	30	18.6	28	19.9
7. I find it difficult to encounter with a patient who has a fatal disease or his/her relatives compared to other patients and their relatives***					
	Agree	115	70.5	126	89.3
	Disagree	43	26.3	13	9.2
	Undecided	5	3.2	2	1.5
9. I find it emotionally difficult when telling a fatal disease or death*					
	Agree	137	84.4	131	92.9
	Disagree	20	12.2	5	3.5
	Undecided	6	3.8	5	3.6

* statistical significance p<0.05
** statistical significance p<0.01
*** statistical significance p<0.001

having children (81.5%) than not having children (66%) (χ^2=12.665, SD=2, p<0.01) (Table 3).

When responses to the questionnaire were evaluated according to death anxiety levels, physicians with a lower level of death anxiety agreed significantly more than physicians with a higher level of death anxiety to the statement "I think that telling the diagnosis of fatal disease openly does not affect patient's prognosis and emotional state" (18.4% vs. 36.1%), (χ^2=12.681, SD=2, p<0.01). Physicians with a lower level of death anxiety responded as "disagree" significantly more than physicians with a higher level of death anxiety to the statement at question #7 "I find it difficult to encounter with a patient who has a fatal disease or his/her relatives more than to encounter with other patients and their families" (9.2% vs. 26.3%) (χ^2=17.182, SD=2, p<0.001). Physicians with a lower level of death anxiety also responded as "disagree" significantly more than physicians with a higher level of death anxiety to the statement at question #9 "I find it emotionally difficult when telling a fatal disease or death" (3.5% vs. 12.2%) (χ^2=8,269, SD=2, p<0.05) (Table 4).

Physicians included in the study were divided into three groups regarding internal medicine, surgery or basic sciences/radiology and compared according to socio-demographic characteristics, frequency of encountering fatal diseases, loss of relatives due to fatal diseases after starting medical practice, receiving training about approach to fatal disease and levels of death anxiety. No difference was found between internal medicine, surgery and basic science/radiology groups regarding marital status, having children and professional titles; however, significant difference was found regarding gender between surgery (69.9% men, 29.1% women) and basic science/radiology groups (48.8% men, 52.2% women) (χ^2=26.403, SD=2, p<0.001) (Table 5).

Frequency of encountering with fatal disease was significantly higher in surgery group (76.8%) than basic science/radiology group (14.6%) (χ^2=52.952, SD=2, p<0.001).

No significant difference was found between internal medicine, surgery and basic science/radiology groups regarding loss of a relative after starting practicing medicine and getting training on death and approach to fatal disease.

When level of death anxiety was examined, high level of death anxiety was found 47.1% in internal medicine group, 39.2% in surgery group and 65.9% in basic science/radiology group. When death anxiety scores were evaluated, death anxiety scale mean score was 7 (5-9) in internal medicine group, 6 (4-9) in surgery group, 9 (5-11) in basic science/radiology group. Level of death anxiety in basic science/radiology group was significantly higher than surgery group (χ^2=8.943, SD=2, p<0.01) (Table 5).

Tablo 5: Characteristics of internal, surgical and basic science/radiology groups

	Internal Medicine (n=138)		Surgery (n=125)		Basic Science/ Radiology (n=41)			
	%	n	%	n	%	n	χ^2	p
Gender								
Female	61.6	85	30.4	38	51.2	21	26.40	<0.001
Male	38.4	53	69.6	87	48.8	20		
Marital Status								
Single	43.5	60	41.6	52	36.6	15	0.89	>0.05
Married	54.3	75	55.2	69	61.0	25		
Divorced	2.2	3	3.2	4	2.4	1		
Children								
Yes	29.7	41	39.2	49	31.7	13	2.73	>0.05
No	70.3	97	60.8	76	68.3	28		
Professional title								
Resident	72.5	100	72.8	91	73.2	30	0.01	>0.05
Academician	27.5	38	27.2	34	26.8	11		
Frequently encountering with fatal disease								
Yes	67.4	93	76.8	96	14.6	6	52.95	<0.001
No	32.6	45	23.2	29	85.4	35		
Loss of a relative due to fatal disease								
Yes	54.3	75	51.2	96	48.8	20	0.50	>0.05
No	45.7	63	48.8	61	51.2	21		
Training of approach to dying patient								
Yes	34.8	48	44.0	55	41.5	17	2.42	>0.05
No	5.2	90	56.0	70	58.5	24		
Level of death anxiety								
Low (0-7 points)	52.9	73	60.8	76	34.1	14	8.94	<0.01
High (+8 points)	47.1	65	39.2	49	65.9	27		

χ^2, Chi-square test

When responses to questionnaire items were compared according to working fields of the physicians, statistically significant differences between groups were found at four items. "All good and bad information about the diagnosis and treatment should be told to a patient with a fatal disease" statement was agreed by 51.2% of basic science/radiology group, 77.5% of internal medicine group and 84.8% of surgery group (χ^2=19.016, SD=4, p<0.001). "I think that patients with fatal diseases are aware of their conditions even their diagnoses were not told to them" statement was also agreed by 48.8% of basic science/radiology group, 74.6% of internal medicine group and 75.2% of surgery group (χ^2=10.920, SD=4, p<0.03). "Professional help is needed when a difficulty occurs in patient-physician relationship when approaching death and terminally ill patient" statement was agreed by 99.3% of internal medicine group, 90.4% of surgery group and 90.2% of basic science/radiology group (χ^2=15.630, SD=4, p<0.004). "If I was the patient, I would have preferred to be told whatever the diagnosis and prognosis is" statement was agreed by 83.3% of internal medicine group, 77.6% of surgery group and 58.5% of basic science/radiology group (χ^2=10.668, SD=4, p<0.05) (Table 6).

At comparisons about death anxiety scale, no significant difference was found regarding level of death anxiety and age and duration of clinical practice; however, when genders were compared, death anxiety was significantly higher in female physicians than males (χ^2=8.572, SD=1, p<0,01). In the physician group who stated high frequency of encountering with dying patient and death, death anxiety was found significantly low (χ^2=4.601, SD=1, p<0.05) (Table 7).

Table 6: Questionnaire items found significantly different when compared according to specialties of physicians.

		Internal Medicine		Surgery		Basic Science/ Radiology	
		n	(%)	n	(%)	n	(%)
2. All good and bad information about the diagnosis and treatment should be told to a patient with a fatal disease**							
	Agree	107	77.5	106	84.8	21	51.2
	Disagree	11	8	8	6.4	5	8.8
	Undecided						
6. Patients with a fatal disease are aware of the situation even their diagnoses were not told to them*							
	Agree	103	74.6	94	75.2	20	48.8
	Disagree	16	11.6	15	12.0	10	24.4
	Undecided	19	13.8	16	12.8	11	26.8
11. Professional help is needed in difficult situations regarding patient-physician relationship when approaching to death and dying patient.**							
	Agree	137	99.3	113	90.4	37	90.2
	Disagree	0	0.0	7	5.6	2	4.9
	Undecided	1	0.7	5	4.0	2	4.9
14. If I was the patient, I would have preferred to be told whatever the diagnosis and prognosis is.*							
	Agree	115	83.3	97	77.6	24	58.5
	Disagree	9	6.5	9	7.2	5	12.2
	Undecided	14	10.1	19	15.2	12	29.3

*statistical difference $p<0.05$
**statistical difference $p<0.01$

Table 7: Assessment done by Death Anxiety Scale

	Low Death Anxiety		High Death Anxiety			
	Median	25-75%	Median	25-75%	z	p
Age	30	(28-36)	30	(28-36.5)	-0.42	p>0.05*
Duration of professional practice	5	(3-10)	6	(2,5-11.5)	0.81	p>0.05*
	n	%	n	%	χ^2	
Gender						
Female	64	(43.3%)	80	(56.7%)	9.30	p<0.01**
Male	99	(60.7%)	61	(39.3%)		
Frequency of encountering with a dying patient						
Low	49	(30.1%)	114	(69.9%)	5.13	p<0.05**
High	60	(42.6%)	81	(57.4%)		

* z, Mann-Whitney U test
** χ^2, Chi-square test

"All good and bad information about the diagnosis and treatment should be told to a patient with a fatal disease" statement was agreed by 78.3% of the physicians; however, when asking style was changed and their opinion about telling the diagnosis openly by saying "cancer" was asked, 77.6% agreed to tell diagnosis openly if diagnosis of cancer is considered for them, 55.6% agreed if one of their relatives are considered and 51% agreed if an adult patient is considered. Significant differences were found between proportion of physicians who required the diagnosis of cancer to be told openly themselves (77.6%) and proportion of physicians who required to be told to a relative (55.6%) and proportion of physicians who required to be told to an adult patient (51.0%). (consecutively $p<0.001$, $p<0.001$).

DISCUSSION and CONCLUSION

In this study, nearly 90% of physicians or over agreed with following statements: patients who have learned that they have a fatal disease pass through stages which cause them to give different reactions to their environment and treatment team, there is need to get training about death or dying patient during or after medical education, professional help is needed when there is a difficulty in approaching death or dying patient, patient has the right to learn about the diagnosis, treatment options and prognosis. On the other hand, agreement with following statements were low: telling diagnosis of a fatal disease openly does not affect prognosis, or emotional state of the patient, patients who know their fatal disease want to talk about death. Although physicians believe that patients have the right to be informed whatever their diagnosis are, when that disease is "fatal", 78.3% of them agreed that diagnosis has to be told to the patient. Physicians think that diagnosis of a fatal disease has a negative impact on the prognosis and emotional state of the patient and also think that patients will not want to talk about death or they are undecided. Cancer diagnosis is not told to the patient routinely in several cultures of Africa, East and South Europe and Middle Asia (23). Reasons of this situation are; physician's desire to protect the patient from psychological stress after learning the diagnosis (23), families' will of not the diagnosis being told due to synonymous perception of cancer and death (23, 24) and at some instances patients' will of not knowing their diagnosis (24).. While family members are reluctant about diagnosis to be told, physicians discuss the diagnosis with family members before the patient. Patient who is willing to be informed is not satisfied when deprived from this information and consequently has distress (24). However, in a study done in general population in Nepal, 80% of people stated that they want to know the diagnosis if it is cancer (23). In a study done in general population in Japan, it was reported that 85.4% of the participants wanted the diagnosis to be told completely, 11.3% wanted to be told partially and 2.9% did not want to be told (24). In a study done with healthy individuals in Turkey, it was reported that 83% of the participants said "yes" and 17% said "no" to the question "If you know that you have lung cancer, would you like to know the truth?". A high proportion of patients would like to be informed about their diagnoses as can be understood from studies performed. It is evident that knowing the diagnosis will have an impact on the emotional state but data about whether this will or not cause a psychiatric disorder are controversial (25,26). Moreover, being informed in patients who know their diagnosis are mainly by intuitive and indirect ways rather than by the support of health professionals and it was reported that this causes higher prevalence of psychiatric diagnoses in patients who know their diagnoses than who do not know with all those negative thoughts attributed to cancer (26). Studies showed that patients would like to hear all good and bad news about themselves despite their families (15). The most important factor in physician-patient relationship is mutual trust so when physician tells his/her patient the truth, he/she will give them the right to participate to the process of decision about his/her life and respects to values of humanity. At this situation, it was reported that appropriate way of telling the truth should be thought but not whether to tell the truth or not (15).

In this study, 94.4% of physicians agreed that training on approaching death and dying patient is necessary during or after medical education. In the study of Gülsoy (27), 84.1% of physicians agreed that physicians should be trained on telling cancer diagnosis or giving bad news. Physicians participated in this study also agreed that they have difficulty in telling a fatal disease or death (88.8%) and they need professional help when they have difficulty (93.8%). For professional help, 87.3% reported that they will refer the patient to a psychiatrist or psychologist, 7% told that they will get consultancy or professional help for themselves, 4.9% told that religious help will be needed and 0.7% told that they will refer the patient to another physician. In the study of Uçar et al. (28), 76% of the participants reported that they want to be informed about the treatment, 59% reported that this information should be given to the patient when he/she can stand for it, in an understandable way and by not disappointing him/

her. It was reported that among patients who want to know the diagnosis, 93% said that this should be told by the physician who diagnosed and treating the patient, 4.4% said that their families and 3.3% said that families and physicians should tell together (28). It was reported that patients need information about their diseases and how this disease will affect them, will use this information to plan their future and to take medical and life decisions, want their physicians to be honest and be ready to know what their patients want to hear and be sensitive to how they will be affected, do not want information more than needed, want their physicians to be open to discuss sensitive issues such as death but do not want to talk before getting ready (29). It was proposed that oncologists give bad news twenty-thousand times during their career and many clinicians experience lack of skills or difficulty about this issue (30). According to data from studies which evaluated the relationship between patient and physician, both physicians and patients are negatively affected from bad news, this causes exhaustion and anxiety at physicians, bad news communicated in a wrong way causes maladaptation to the news and negative health consequences (30). Studies showed that patients who experienced supportive physician interaction can cope with the terminal stage disease better, their adaptation to the disease increases and anxiety and other psychiatric disorders are seen less in these patients (9,31,32).

In this study, 78.3% of the physicians agreed with the statement "all good and bad news about diagnosis and treatment of a patient with fatal disease should be told", 77.6% agreed with the statement "I would like to be told what the diagnosis or prognosis is if I were the patient", 66.8% agreed with the statement "I would like the diagnosis and prognosis to be told if the patient is my relative". However, if the fatal disease is "cancer", then proportion of agreement with telling the diagnosis openly was 77.6% when diagnosis is considered for the physician himself, 55.6% when a relative is considered, 51% when an adult patients is considered. This finding pointed out that cancer is considered separately from other fatal diseases. In the study of Gülsoy (27), opinion of physicians about telling the diagnosis differs when cancer was diagnosed to the physician himself, a relative or his/her patient similar to our study. In the same study, if the physician was diagnosed cancer, then 95.1% of them wanted to know the diagnosis, 84.1% wanted to know if a relative was diagnosed cancer and only 59.4% agreed with telling the diagnosis to his/her patient. In a multinational study done in 2000, majority of the clinicians from US but minority of the physicians from Japan thought that untreatable and advanced cancer should be told to the patient (33). In a study done in medical students, prevalence of believing in telling the diagnosis decreases from 1. to 6. class of the medical faculty (34). In another multinational study, oncologists from Africa, France, Hungary, Italy, Japan, Panama, Portugal and Spain reported that less than 40% of their colleagues would like to use the word "cancer" or tell the diagnosis to the patient (35). When physicians themselves, their relatives of patients are considered, differences of attitude to tell the diagnosis reflect the paternalistic patient-physician relationship (36).

In this study, when comparison was done regarding death anxiety, physicians with a high level of death anxiety agreed with the statements "I find it difficult to encounter with a patient who has a fatal disease and their families more difficult than other patients" and "I find it emotionally difficult when telling a fatal disease or death" more than physicians with lower level of death anxiety but agreed less to the statement "Telling diagnosis of a fatal disease will not negatively affect patient's prognosis and emotional state". It should be taken into consideration that problems of encountering with a dying patient and knowing diagnosis of fatal disease have a negative impact on prognosis may reflect own death anxiety of physicians.

In this study, death anxiety was found to be higher in female physicians than males and lower in physicians encountering with higher number of dying patients. Death anxiety was also found high in women in the study of Templer (22). It is not clear whether death anxiety decreases by encountering fatal diseases more or people with a higher level of anxiety choose specialties with less likelihood of encountering with these types of patients. However, according to this study, men make up the majority of physicians working in surgical sciences than basic sciences/radiology and also

encounter with dying patients more and have a lower level of death anxiety. Physicians from basic science/ radiology agreed with statements "All good and bad information about diagnosis and treatment should be told to the patients with a fatal disease" and "Patients with a fatal disease are aware of the truth even diagnosis was not told to them" more than physicians from surgical sciences.

Most of the patients want to know the truth, some of them do not want to know all of the details and some of them do not want to know their diagnoses. Physicians often think that there are patients which truth can or cannot be told or telling truth may differ for each patient. It is generally decided whether to tell the diagnosis or not according to age, gender, history, occupation, family and social status, personality, religious faith, physical condition and prognosis. Physicians prefer not to tell if the patient is woman, elderly, not well-educated and unemployed (35). It was reported that it will not be appropriate to make a full explanation without looking at whether the patient is ready or not (9). In paternalistic patient-physician relationship, physicians have power on patients and they are reluctant to ask or discuss. In US, a different approach used at patients from different cultural backgrounds is to ask in written how much they are willing to get informed. This method supports determining the attitude of physician about telling the truth (35).

In conclusion, this study brought up data which showed difficulties and challenges about approaching dying patients and death which is an area thought to be neglected in medical profession. There is need for new studies for understanding, discussing and increasing awareness of "good death" both for the benefit of patients and physicians when a fatal disease or cancer is considered and to pioneer to determine the path in this field.

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