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Understanding patients:
let's talk about it
A study of cancer communication

Abstract
As part of a project on quality of life in patients with lung cancer, an investigation was carried out to examine how patients reacted to the study. A group of 82 patients attending a chest clinic were interviewed by means of a short questionnaire. They were asked to indicate whether an interview was preferable to filling in a questionnaire and whether a home visit was preferable to a clinic interview, and their feelings about interviews. In addition, we documented our observations during the study period. All patients agreed to participate in the study, of whom, 56 patients (68%) preferred to be interviewed, 8 (10%) preferred to fill in a questionnaire by themselves, and the remaining 18 (22%) expressed no preference. Forty-one patients (50%) preferred to be interviewed at their homes, 13 (16%) in the clinic, and 28 (34%) expressed no preference. Nearly all patients (96%) indicated that they found being interviewed very or quite comfortable. Our observations indicated that patients were pleased to talk about and discuss their perceived cultural and social values or daily life experiences. The findings suggest that, despite the strenuous attempts by clinicians to deliver effective health care, proper communication with patients remains limited. The finding has some implications for community care.

Key words
Cancer communication
Doctor-patient relationship
Community care

Introduction
Despite advances in medical technology, communication remains the primary mechanism of relationship between physicians and patients [23]. Several purposes have been established for such communication: interpersonal interaction [19], exchange of information [20] and decision making [6, 24]. These occur during the process of care. It is believed that all these influence outcomes such as patient satisfaction [4], patient compliance [21], and patients' health status and quality of life [11, 12, 15]. The question is, how good are health professionals at understanding patients' concerns? This was investigated by simple measures using both quantitative and qualitative approaches. Data were obtained during a study on quality of life in patients with lung cancer. This paper addresses patients' attitudes to being assessed by questionnaire or by interview and whether they prefer to be assessed at home or in the clinic. These are important questions since many clinicians argue that assessing patients through interview is too upsetting particularly if it is conducted in the home environment. This was part of a current project carried out in the northern sector of Glasgow. This paper reports the preliminary findings and discusses their implications.
Patients and methods

Design

A prospective study is being conducted to measure quality of life in patients with lung cancer. Data collection is expected to be completed by end of 1995 and the results are yet to be analysed. To collect data a series of interviews with patients attending a chest clinic in a hospital in the northern sector of Glasgow are being carried out. Interviews are conducted at patients’ homes or in the clinic. Permission was obtained from the hospital ethical committee, general practitioners (GPs), clinicians and the patients themselves. Quality of life is assessed at baseline and 3 months later. Baseline assessments are scheduled after referral by GPs and before diagnosis is made by consultants. At this stage for each suspected case, 1 patient with chronic respiratory disease is interviewed as a control. The quality-of-life assessment team are blind to this selection, the nature of the disease and diagnosis. At the time of the baseline interview patients did not know their confirmed diagnosis, but they knew that they were under investigation. All lung cancer patients were informed at a return appointment when the clinical tests were completed. Follow-up assessments are scheduled 3 months later for those with a confirmed diagnosis of lung cancer.

Questionnaire

In addition to the standard measures of quality of life (the Nottingham Health Profile, NHP; the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire, EORTC QLQ-C30; and its companion lung cancer questionnaire EORTC QLQ-LC13), a short questionnaire was administered to investigate how patients reacted to the study. Patients were asked:
• Do you prefer to fill in a questionnaire or to be interviewed?
• Do you find it difficult to fill in a questionnaire?
• Do you find being interviewed uncomfortable?
• Do you prefer to be interviewed at home or in the clinic?

Response categories for the first question were (fill in a questionnaire, to be interviewed, either, don’t know), these for the next two questions were (very, quite, not very, not at all), and for the last question were (home, clinic, either, don’t know).

The Carstairs and Morris Deprivation Category Index [5] was used as an indicator of socio-economic status ranging from 1 (affluent) to 7 (deprived).

Analysis

The quantitative data were analysed in a descriptive fashion followed by statistical tests [exact 95% confidence interval (CI), $\chi^2$ and analysis of variance where necessary]. The qualitative information was documented during the study period and, as examples, some of these cases are reported here.

Results

Patients

A total of 82 interviews have been analysed. At the time of this report 34 patients (41%) had a confirmed diagnosis of lung cancer, 18 patients (22%) were definite controls (respiratory diseases), and the final diagnosis in 30 patients (37%) was yet to be confirmed. Forty-five patients (55%) were male and 37 (45%) were female. The mean age was 66.7 years ranging from 24 to 84. Fifty-nine patients (72%) were from deprived areas and the rest were from middle class (13%), and affluent (15%) backgrounds. The characteristics of the patients are shown in Table 1. There were no significant sex or deprivation category differences among these three groups of patients (sex $\chi^2=1.4$, df=2, $P=0.5$; deprivation category $\chi^2=2.8$, df=4, $P=0.6$). The analysis of variance indicated that the mean age was not different either ($P=0.8$).

Interview versus filling in a questionnaire

There were concerns that patients may prefer to fill in a questionnaire rather than be interviewed. There was an assumption that patients with cancer are upset and, because of the crisis of cancer diagnosis, it is difficult to discuss quality of life issues with them. Thus, if we ask them to fill in a questionnaire, this may reduce patients’ burden. But the results of our analysis showed otherwise. Out of 82 patients, 56 (68%) preferred to be interviewed, 8 patients (10%) preferred to fill in a questionnaire, and 18 patients (22%) expressed no preference (Table 2). There was no significant difference between different groups of patients, i.e., patients with lung cancer, suspected lung cancer cases, and those with respiratory diseases ($\chi^2=6.14$, df=4, $P=0.2$). To test whether preference for interview was due to difficulty in filling in a questionnaire, we asked patients to indicate whether they have any difficulty in doing so or not. Fifty-four patients (66%) stated that it was “not at all”, 14 (17%) “not very”, 12 (15%) “quite difficult” and two (3%) “very difficult” to fill in a questionnaire. There was no significant association between preference to be inter-