Original Research Reports

Expectations and Level of Satisfaction of Patients and Their Physicians: Concordance and Discrepancies

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Background: *Identifying discrepancies between patients' expectations for support provided by their physicians, and physicians' appraisal of the support they provide to their patients, is a key factor in constructing effective doctor-patient communication.* **Objective:** *The current study proposes and explores a paradigm for assessing possible gaps and overlaps between perceptions of patients with cancer and physicians about the "actual" and the "ideal" (desired) emotional and cognitive support oncologists provide to patients.* **Methods:** *Participants included 1027 patients with cancer and 47 senior oncologists. Patients' and physicians' levels of expectations and satisfaction with the emotional and cognitive support offered by physicians were assessed using a quantitative measure of discrepancy between the actual and the ideal situation. The measure was developed for this study and tested on a random sample of 200 patients and 17 oncologists.* **Results:** *The results indicated consistency between physicians' and patients' perceptions of the needs and support that the patients received. Nevertheless, oncologists did not feel highly trusted by their patients, oncologists desired less involvement of patients in the treatment plan than the patients expected. Oncologists thought that they actually provided the desired levels of explanation to patients' families, whereas patients thought their families got less explanations than expected.* **Conclusion:** *Actual and ideal levels of communication should be described from the points of view of both physicians and patients to better understand the complex picture of patient satisfaction. Oncologists should consider patients' expectations for support vs their own expectations to effectively address patients' needs.*

(Psychosomatics 2015; 56:521–529)

BACKGROUND

The growing prevalence of cancer worldwide, as well as the complexity and diversity of diagnoses and treatment options, is intertwined with long-term dependency on medical professionals and an increase in patient need for effective and tailored care.[1–6]

Patient evaluation of health care services and measurement of patient satisfaction are highly important in improving doctor-patient partnership, and ultimately, improving the overall quality of care.[1–3,7–9] Moreover, communication and support are vital components of patient satisfaction with care.[4]

In their review of communication training for Health Care Providers in cancer care, Uitterhoeve et al.

suggested that lack of recognition and response to the patient's feelings—particularly his needs, fears, and expectations—was a key factor in hindering effective physician-patient communication.[10] To achieve effective communication, physicians need to be aware of their patient's level of satisfaction with the support that they provide.[10–13]

The current study describes the possible overlap between physician perception of support and patient satisfaction with that support. We propose a paradigm for identifying possible discrepancies.[7,14] Patient satisfaction was measured by examining the differences between patient evaluations of actual support vs ideal support provided by the physician. Physician appraisal of actual vs ideal support to the patient was likewise measured. The possible overlap between the 2 measures is defined as the "zone of effective communication."[15] We suggest that it is within this zone that effective communication and mutual understanding can be developed and achieved. Clearly, the contours of this zone are influenced by the sociodemographic background as well as the cultural and psychologic variables of both the groups: patients and physicians.

Measuring satisfaction as a conceptual discrepancy is rooted in the theoretical and research literature on communication, which asserts that satisfaction is relative to an individual's needs and is largely defined by the perceived discrepancy between actual experience and patient's ideal expectations.[7,8,15,16] The same concept can be applied to physicians. Physician satisfaction with support provided to the patient can be defined by the perceived discrepancy between the actual and the ideal experience of support provided.

The goal of the current study is to explore and understand the possible discrepancies and concordance between physician's self-appraisal and patient's satisfaction with the physician communication and support to the patient.

PARTICIPANTS AND METHODS

Data for the current study were derived from an ongoing multicentered research project concerning physicians' and patients' expectations, satisfaction, and distress.[16] In the current study, we analyzed and compared only measures of physician self-appraisal and patient satisfaction. The study included a representative sample of patients undergoing routine consultation obtained from the ambulatory outpatient clinics of 4 major oncology institutes within the Israeli health care system. The study received approval from the Ministry of Health and the Medical Ethics Review Committees of all the 4 institutions. Each participant was required to sign a written informed consent before he or she enrolled in the study.[16] In total, 1079 patients were approached—1027 (95.2%) patients participated, whereas 52 (4.8%) declined to take part. No significant differences were found in the sociodemographic and medical background variables between the groups.

Oncologists were recruited from the same 4 clinics. Inclusion criteria were formulated to comprise oncologists with 7–10 years of experience, who have lived in Israel for at least 15 years. Based on the common practice at each clinic, these criteria ensured that the participating oncologists had treated the selected cohort of patients in a long-term professional relationship.

In total, 47 of 49 eligible senior oncologists responded to our interview. It is feasible that the high and unusual accrual rate is because of the detailed explanation given to physicians regarding the opportunity to improve physician-patient satisfaction, as well as the anonymity of the data collection procedure (concurring with the request of the Ethics Committees). Anonymity of the oncologists was a required factor enabling us to conduct the study, especially in Israel where the number of senior oncologists is small, and thus they are easily identifiable. Owing to the anonymity requirement, comparisons could not be based on specific interactions between dyads of patients and physicians. Physicians were asked to relate to their current patients "in general."

Instruments

Sociodemographic and Medical Variables

Sociodemographic and medical data regarding patients included wide-ranging information.[16] To ensure the anonymity of the oncologists, however, no identifying sociodemographic data beyond age and gender were collected.

Satisfaction and Appraisal Measures

Satisfaction and appraisal measures were developed for the current study (see section Instrument Development).

Measure (Appendix 1) included 8 items with a 4-point Likert scale ranging from responses of "not at all" (1) to "very much" (4). Patients and oncologists responded to each item, first describing the actual situation and then stating the imagined ideal situation. Items were based on 3 domains of physician support: cognitive support (i.e., explanation about the disease and treatment), emotional support, and interaction with family members (i.e., support and explanation provided by the oncologist to the family).

The internal consistency values (Cronbach α) for the actual items were 0.82 (patients) and 0.68 (oncologists). The Cronbach α values for the ideal items were 0.78 (patients) and 0.68 (oncologists). The somewhat lower values of the oncologists' measures (0.68; 0.66) reflect a small variability within the oncologists' answers (mean standard deviation [SD] of 0.53 for the "actual" items and 0.47 for the "ideal" items).

Instrument Development

In reviewing dimensions of satisfaction proposed by studies of physician support, we identified 3 basic domains: cognitive support (i.e., explanation about the disease and treatment), emotional support, and physician interaction with the patient's family (which is considered in many cases to be the basic unit of care).[7,14,17–22] These broad domains were transformed into a set of research items. The initial set was refined through a random pilot study (including 200 patients and 17 oncologists), which led to the final definition of 8 items.

These measures adhere to the criteria for developing a new instrument as proposed by Juniper et al.: defining a specific goal (i.e., evaluating satisfaction on the basis of the perceived level of support, either patient or physician), using items that are grounded in pilot research and feasible administration (forms can be completed in less than 20 min).[23]

Data Analysis and Methodologic Considerations

Responses were found to be positively skewed, with only a small or 0% of participants who gave answers indicating low agreement with each of the items (a score of 1 = "not at all"). Based on the nature of the data and on the literature review, we focused only on answers indicating the highest agreement with each of the items (a score of 4 or "very much agrees").[9,19]

At the first stage, we compared the percentages of patients and oncologists reporting high agreement (a score of 4) on each of the 16 items (8 actual and 8 ideal), promoting a clear understanding of variations between items. As the study protocol did not allow one-to-one matching of oncologists and patients, data analysis was based on an unmatched group comparison, applying the Fisher exact test. As each item was compared separately between the groups, we used a conservative approach to data analysis by applying the Bonferroni correction, with *a priori* significance level set at 0.05/16 = 0.0031.

At the second stage of analysis, we calculated the discrepancy between the "actual" and the "ideal" versions for each item, separately for each group (physicians and patients), focusing on the percentage of items with a perfect match (zero discrepancy) between the "ideal" and "actual" versions. Comparison of these discrepancy measures between physicians and patients was also conducted using the Fisher exact test with Bonferroni correction, and *a priori* significance level was set at 0.05/8 = 0.00625.

It has to be noted that although conclusions could not be drawn on the dyadic level, the methodology used (having both "ideal" and "actual" items) allowed us to compare levels of satisfaction and appraisal within each group (patients and physicians) and to compare these discrepancies between both the groups.

RESULTS

Sample Characteristics

The mean age of the 1027 patients in the sample was 55 years (SD = 15.10), and one-third of the patients (32.9%) were men. The most common cancer type was breast cancer (36.7%), followed by colorectal cancer (12.7%). These results concur with the statistics of the Israel National Cancer Registry, which identifies breast cancer as the most common cancer in Israel, constituting 30.2% of cancer incidents among Israeli women followed by colorectal cancer (13.2% of women and 14.1% of men).[24]

The mean Karnofsky score was 92 (SD = 11.27) and the average time span since diagnosis was 4.20 years (SD = 3.83 mo). (For a detailed description of the patient sample, see Goldzweig et al.[16]) Of the 47

oncologists, 29 (62%) were men and 18 (38%) were women. Their mean age was 45 years (SD = 8.07).

Patient and Oncologist Answer Distribution

Table 1 presents the distribution of patients and oncologists with high score responses (4 = very much agrees) concerning the actual and ideal items. As indicated in the table, oncologists and patients were in high concordance.

Overall, 40%–60% of patients agreed very much with the positive communication statements concerning the "actual physicians."

Overall, 64%–79% of oncologists agreed very much with the positive communication statements concerning the "actual physicians" with 2 notable exceptions: Only a third of oncologists felt that patients trust them (32% of the physicians vs 57% of

the patients, $p < 0.001$) and that patients are involved in the treatment decisions (32% of the physicians vs 40% of the patients).

With regards to items related to the "ideal" situation, oncologists' expectations for trust from their patients were higher than those of the patients (92% of physicians vs 72% of patients, $p < 0.001$). Nevertheless, patients expected to be involved in treatment decisions more than what was desired by the oncologists (34% of the physicians vs 71% of the patients, $p < 0.0001$).

Discrepancy Measure

For both patients and oncologists, discrepancy measures were defined similarly (i.e., the difference between the "actual" and the "ideal" versions of the items). Based

TABLE 1.   Frequencies of Answers Oncologists' and Patients' 'Very Much Agree' Responses

Item	% Of "very much" answers		
	Patients Freq. (%)	Oncologists Freq. (%)	Patients vs oncologist
The physician explains the planned treatment			
Actual	594 (58)	32 (68)	$p < 0.176$
Ideal	804 (78)	44 (94)	$p < 0.009$
I can turn to the physician with problems			
Actual	623 (61)	36 (77)	$p < 0.032$
Ideal	914 (89)	39 (83)	$p < 0.23$
I can speak freely with the physician			
Actual	576 (56)	33 (70)	$p < 0.07$
Ideal	922 (88)	37 (78)	$p < 0.073$
I can trust the physician			
Actual	585 (57)	15 (32)	$p < 0.001$[*]
Ideal	927 (90)	39 (83)	$p < 0.128$
The physician explains the illness to me			
Actual	504 (49)	32 (68)	$p < 0.011$
Ideal	816 (79.5)	31 (66)	$p < 0.042$
The physician encourages me			
Actual	449 (44)	30 (64)	$p < 0.01$
Ideal	741 (72)	43 (92)	$p < 0.001$[*]
The physician explains the illness and treatment to my family			
Actual	418 (41)	37 (79)	$p < 0.0001$[*]
Ideal	647 (63)	38 (81)	$p < 0.013$
The physician includes me in planning the treatment			
Actual	415 (40)	15 (32)	$p < 0.288$
Ideal	725 (71)	16 (34)	$p < 0.0001$[*]

Freq. = frequency.

Note: Comparisons between patients and oncologists were done using the Fisher exact test; based on the Bonferroni correction, *a priori* significance level was set at 0.05/16 = 0.0031.

[*]$p < 0.0031$.

on a review of the relevant literature and the positively skewed nature of the items, we differentiated only between oncologists and patients who had a zero "delta" score (i.e., subtracting actual item from ideal item) and the rest of the cohort. This procedure enabled us to avoid a positive skew of results.

Considering each item separately, approximately 50% of patients reported a high level of concordance between the actual and the ideal situation (Table 2). Items with relatively lower concordance were (A) "including the patient in planning the treatment" and (B) "explanation to the family." Oncologists' concordance between the actual and the ideal situation varied between 40% ("the patient can trust the physician") and 85% ("the physician explains the treatment to the family"). Table 2 presents also a comparison of the percentages of patients vs physicians reporting high concordance between the actual and the ideal situation. Significant differences were found in the following items: (A) "speak freely with the physician," (B) "encouragement by the physician," (C) "explanation to the family," and (D) "inclusion in planning the treatment." In all of these items, higher percentages of physicians (in comparison to patients) reported concordance between the actual and ideal situation.

It is of interest to note that the item "explanation to the family" was ranked second lowest among patients, but highest among oncologists.

DISCUSSION

This study proposes a paradigm for evaluation of patient satisfaction and physician appraisal of support offered by the physician to the patient. Both perceptions are defined in terms of the gaps between actual and ideal support. The framework focuses on emotional and cognitive parameters that may be perceived differently by patients and physicians: (1) the actual situation; (2) the ideal situation; (3) and the differences between the actual and ideal situations.

Results illustrate the complex relations between physician and patient perception of their medical situation. Although some discrepency between oncologists and patients is to be expected, overall the degree of concordance was very high. The picture that emerges is far from the stereotypical image of the emotionally withdrawn physician who is unable to understand her patient and does not provide sufficient relational dialogue.[25–28]

Nevertheless, some discrepancy was found between the cohort of patients and physicians. The Figure presents the calculated mean for each of the ideal variables, which was added to the results to demonstrate the highly unusual variability within and between each group. In a number of cases, patients were more reticent than their oncologists regarding disclosure of communication. Thus, only 72% of patients vs 92% of oncologists thought that ideally,

TABLE 2. Frequencies of High Match (Ideal-Actual): Oncologists and Patients

| Item	% High match (ideal-actual)				
	Patients		Oncologists		Patients vs oncologists
	Freq. (%)	95% CI (%)	Freq. (%)	95% CI (%)	
The physician explains the planned treatment	611 (59.5)	56.5–62.5	31 (66)	52–80	$p < 0.45$
I can turn to the physician with problems	606 (59)	56–62	37 (78.7)	67–91	$p < 0.06$
I can speak freely with the physician	589 (57.4)	54–60	38 (80.9)	69–92.5	$p < 0.001$[*]
I can trust the physician	589 (57.4)	54–60	19 (40.4)	26–55	$p < 0.024$
The physician explains the illness to me	539 (52.5)	49–56	21 (44.7)	30–59	$p < 0.3$
The physician encourages me	506 (49.3)	46–52	34 (72.3)	59–86	$p < 0.003$[*]
The physician explains the illness and treatment to my family	478 (46.5)	43–49	40 (85.1)	74.5–96	$p < 0.0001$[*]
The physician includes me in planning the treatment	472 (46)	43–49	33 (70.2)	57–84	$p < 0.001$[*]
Total	166 (16.2)	14–18	10 (21)	0.9–33	$p < 0.32$

Freq. = frequency.

Note: Items are ordered according to patients' satisfaction levels (highest to lowest).

Comparisons between patients and oncologists were done using the Fisher exact test; based on the Bonferroni correction, *a priori* significance level was set at $0.05/8 = 0.00625$.

[*]$p < 0.00625$.

FIGURE.   Means of the Ideal Oncologist Support Variables by Oncologists and Patients.*
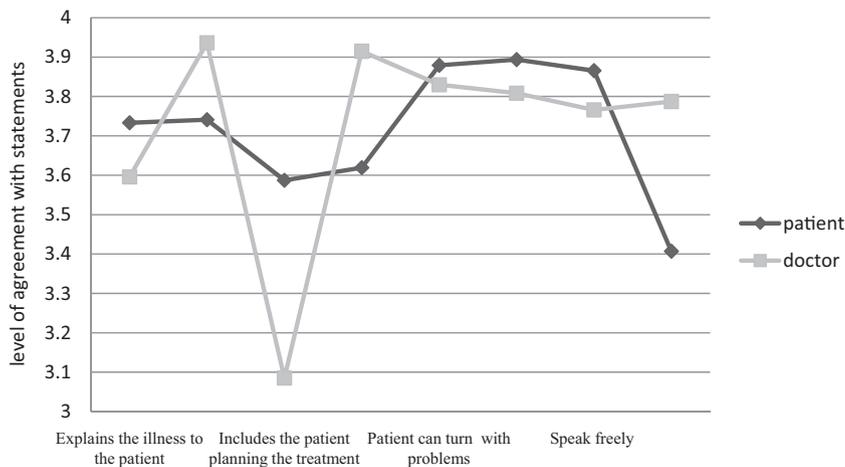
A calculation of the means for each of the "ideal" variables was added to the results to demonstrate the highly unusual diversity within and between each group.

the oncologist "should encourage the patient to the highest degree."

In the area of "explanation to the family about the illness and its treatment," we note a phenomenon that can be described as "double discrepancy." When asked "how much explanation should ideally be given to the family," oncologists wanted to provide more than was indicated as necessary by patients. By contrast, when asked "how much explanation is actually given," oncologists reported that they provide more explanation than patients believed their families actually received. Possible explanations are that the intention of physicians is greater than its actual effect over the patients or that the physicians did not follow their own intentions in providing explanations to the family. Indeed, the most common reason given by physician for not providing full explanations to the family (even though they thought it was needed) was the physicians' perception that patients desire to protect their families, regardless of the physicians' opinion.

Although the overall level of reported patient satisfaction was very high, professionals in communication training must be aware of the perceived discrepancies.[29] In comparison with oncologists, patients were significantly less satisfied (higher discrepancy between "ideal" and "actual") with the options of speaking freely to their physician and their need to be "encouraged by them." These differences may be embedded in the cultural diversity present in both patients and oncologists.[30,31] Thus, it may be

possible that in the eyes of a patient, an oncologist who offers to the patient overt medical information and "freedom of decision" is lacking in his professional authority and understanding of the patient's high vulnerability.[32]

The discrepancy regarding patient inclusion in the treatment plan concurs with studies which found that patients are not satisfied concerning communication with their oncologist about treatment goals.[33] It seems that patient involvement in shared planning could yield relevant psychological benefits, such as a sense of partnership and control over their medical procedure, in addition to promoting active coping and adherence to difficult treatment regime.[12,31] In addition, "planning the treatment" might hold a different meaning for the patient when compared with the oncologist. Oncologists tend to be very specific regarding "… statistics and medical details,"[31,34] whereas a patient's cognitive capacity to absorb information is mediated by psychological distress, uncertainty, and the need for reassurance and hope.[35,36]

Concepts such as treatment planning or family involvement may have different meaning for patients and physicians in different cultures. Thus, within the more traditional values system of the Israeli society, patients do not necessarily expect "equal partnership" between physicians and patients. Training of physicians in empathic communication is desirable process if the training process is embedded within the cultural norms and values of the relevant society.

Notwithstanding our findings, there are limitations to the study. Based on the positively skewed nature of the data, we chose to focus only on responses indicating the highest agreement with each item. Analysis along a continuum may have produced somewhat different results. Our results could have been influenced by the specific norms and values of the Israeli culture. Although Israel is considered a Western country, family structure and cultural values follow a more traditional Middle-Eastern paradigm.[28,29] In many cases, medical decisions are not an individual choice but rather a family responsibility. Israeli oncologists, nevertheless, have Western training whose emphasis is on values such as patient autonomy, free choice, and individuality.[31] These differences may explain why, in the current study, patients desired more explanations to family then what they perceived as they actually get. However, physicians felt that they gave the optimal level of explanations to the family. It may very well be that the discrepancy between physicians and patients concerning explanations to the family is embedded in the cultural differences between physicians and patients in Israel.

Exclusion of hospitalized patients in terminal stages of the illness from participating in the study restricts the findings. Although the participating physicians included almost all senior oncologists, the sample is small. A more comprehensive approach may be to enable the inclusion of oncology residents or to follow the development of the oncologists' attitude by means of a longitudinal study. Nevertheless, strict adherence to a protocol ensuring oncologist anonymity did not enable patients to be matched to their oncologists. Our conclusions, therefore, are based on differences between groups, rather than differences between individual physician-patient pairs, an analysis that would have yielded more specific information.

CONCLUSION

The high concordance between physician and patient views is encouraging. Nevertheless, physicians should be aware and evaluate the feasible discrepancy between what they perceive they provide and what patients need, especially during the lengthy trajectory of the cancer illness.[37]

Evaluation of discrepancies may serve as the first step toward more effective and tailored patient-physician communication. Such understanding can support and facilitate an open dialogue in oncology as well as in many other areas of medical care. The described model is a fruitful background for effective communication training. It can be identified by including simple and direct questions about patients' expectations during each interactive meeting. Such an evaluation may promote physician's awareness of the subjective nature of patient's needs.

APPENDIX 1

The Patient-Doctor Discrepancy Model (PDDM) questionnaire includes 8 items, in 4 versions.

The versions:

A. Patient—actual situation: "To what extent is your physician…?"
B. Patient—ideal situation: "To what extent do you think your physician should ideally…?"
C. Oncologist—actual situation: "To what extent do you think you are…?"
D. Oncologist—ideal situation: "To what extent do you think you should ideally…?"

The answer scale is:
1 = not at all
2 = to some extent
3 = a lot
4 = very much

The items:

1. Explain about the planned treatment
2. Can turn to with problems
3. Can speak freely with the physician
4. Can trust
5. Explains the illness
6. Encourages
7. Explains about the illness and treatment to my (the patient's) family
8. Includes me (the patient) in planning the treatment

For example:

Item 1 verse 1: To what extent does your physician explain the planned treatment?

Item 1 verse 2: To what extent do you think your physician should ideally explain the planned treatment?

Item 1 verse 3: To what extent do you explain the planned treatment to your patient?

Item 1 verse 4: To what extent do you think you should ideally explain the planned treatment to your patient?

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