Perspectives from older adults receiving cancer treatment about the cancer-related information they receive

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Received: February 28, 2015, Accepted: June 09, 2015

Objective: Cancer patients have reported that information plays a significant role in their capacity to cope with cancer and manage the consequences of treatment. This study was undertaken to identify the importance older adults receiving cancer treatment assign to selected types of cancer-related information, their satisfaction with the cancer-related information they received, and the barriers to effective information provision for this age group. Methods: This study was conducted in two phases with separate samples. Six hundred and eighty-four older cancer patients receiving treatment completed a standardized survey and 39 completed a semi-structured interview to gather perspectives about cancer-related information. Data were analyzed for 65-79 years and 80+ year groups. Results: Information topics about their medical condition, treatment options, and side effects of treatment were rated as most important by the older cancer patients. Women assigned a higher importance ratings than men to information overall ($t = 4.8, P < 0.01$). Although participants were generally satisfied with the information, they received many described challenges they experienced in communicating with health care professionals because of the medical language and fast pace of speaking used by the professionals. Conclusions: The older cancer patients in this study endorsed the same topics of cancer-related information as most important as has been reported in studies for other age groups. However, this older group recommended that, during their interactions with older individuals, health care professionals use fewer medical words, speak at a slower pace, and provide written information in addition to the actual conversation.

Key words: Older cancer adults, information perspectives, supportive cancer care

Introduction

Cancer and its treatment have more than a physical impact. There are emotional, psychosocial, and practical consequences as well. Individuals who have been diagnosed with this disease have indicated the importance of information, effective communication, and emotional support in helping them cope with these consequences. Given its importance, the provision of relevant, understandable information is considered a dimension of quality cancer care.

Cancer is, most frequently, a disease of aging. Forty-three percentage of cancer diagnoses are made in individuals who are over 70 years of age. As the population profile changes over the next decade, and the “baby boomer” generation moves into this age bracket, we can anticipate having increasing numbers of older adults in our cancer centers. This age group will form a significant proportion of the patient population attending cancer programs.
Aging is a highly individualized, multidimensional process and the older population is highly diverse. Their approaches to learning and coping differs from younger individuals. The services that would benefit older adult cancer patients and assist in their understanding of the disease and adaptation may need to be adapted. They may have different requirements for information, communication, and support both in terms of content and the ways in which they access this information. To date, this has been an understudied area.

**Background**

**Provision of information for cancer patients**

Information has an important role in helping cancer patients cope with the effects of cancer treatment and its consequences. Information has been cited as a critical need by individuals at all points of the cancer journey. The evidence supports the idea that most, although not all, cancer patients want to be fully informed and receive as much information as possible.

The information helps individuals in a number of ways. Relevant information assists in decision-making and problem-solving, reducing anxiety or emotional distress, and in preparing for future events. Without relevant information, the skills needed for self-management may not be learned, and patients may not be able to engage in informed decision-making about their care. The type of information cancer patients want to receive has been well-documented. The information reported as most important relates to the medical condition (cancer as a disease), its treatment, and side effects. Although not rated as highly, patients perceive it is also important to have information about emotional changes, practical issues, and the availability of support services.

At the same time, the evidence illustrates that different people want different types and amounts of information at different times. Given individuals learn and cope in different ways, the nature of the information they require and the way it should be delivered may differ. One of the challenges clinicians face in providing information was to determine and be able to manage who requires what information, at what point in time. In addition, if an individual is experiencing emotional distress, their capacity to comprehend information can be compromised.

This is particularly the case, if the information is new or complex.

How cancer care team members communicate is an important aspect in providing information to cancer patients. Cancer patients expect the information; they receive will be relevant to their situation, correct, current (up-to-date), understandable, and provided first and foremost by the physician and nurse. They also recommend that information be available in various formats to match different individuals learning styles. However, patients across Canada report there are often gaps in the provision of information in ambulatory oncology settings.

In summary, a good deal of evidence is available from a cancer patient perspective to guide cancer teams in organizing general initiatives regarding the provision of information. However, given the growing population of older adults, it remains unclear if their learning and coping needs would require a targeted approach to information provision.

**Potential challenges for older adult cancer patients**

The older adult facing a cancer diagnosis and treatment can be facing a variety of challenges, which could influence their accessing and understanding cancer-related information. As the body ages, deterioration can occur in functional, emotional, socioeconomic, and cognitive areas at various rates of decline. Preexisting health problems and conditions may influence the actual decisions to treat cancer. In some cases, barriers to treatment are perceived as functional status, available social support, and transportation. Concerns are frequently raised about the capacity of older adults to tolerate the toxicities associated with treatment and the impact of co-morbid conditions on the final outcomes.

The decreasing mobility, diminishing cognitive status, and increasing frailty that can accompany growing older may limit tolerance for treatment, as well as the capacity to cope with the added burdens of cancer. This age cohort may also struggle with poor eyesight, diminished hearing capacity, and issues of literacy. Such factors can influence the capacity for older adults to attend to and absorb any education or learning about cancer and its treatment. These factors would suggest adjustments are needed in health provider communication, teaching materials, teaching time, and educational approaches.

In addition, older adults may face specific attitudes of ageism on the part of health care providers. Such attitudes can influence the way the provider speaks with the older person, includes them in the conversation, involves them in the decision-making about their care, and what education interventions they recommend. It has also been reported that older adults may cope better psychologically than younger individuals because of their life experiences and coming to terms with their mortality. On the other hand,
the current cohort of older adults is less likely to challenge a physician’s authority and are often more comfortable having someone else make the decisions for them. These factors may also influence the perspectives of older cancer patients on the information they require. We thought that documenting perspectives of older adults undergoing cancer treatment about the cancer-related information they receive could inform future patient education programing and delivery.

**Purpose**

This study was undertaken with the aim of documenting perspectives of older adults receiving cancer treatment about the cancer-related information they receive. The specific objectives of the work were fourfold:

1. To identify the importance older cancer patients on treatment assign to specific types of cancer-related information.
2. To identify the satisfaction older cancer patients on treatment have with the information they received.
3. To determine if there were significant differences in the ratings of older adults cancer patients in two age groups (i.e., old = 65-79 years; very old = 80+ years), and
4. To explore the barriers to effective cancer-related information provision for older cancer patients on treatment.

We anticipated the work would allow deeper insight into specific information needs of the older adult receiving cancer treatment and provide a basis for future program design and patient education development.

**Materials and Methods**

**Study design**

This study was approved by the Institutional Research Ethics Review Board. It was conducted in two phases with separate samples. The first phase used a standardized survey to gather data from a large convenience sample of older adults receiving cancer treatment about the importance and satisfaction with the cancer-related information they had received. The second phase utilized a small convenience sample of individuals 65 years and older who participated in a semi-structured interview concerning their perspectives about the provision of information. The findings from both phases will be summarized in this article.

**Patient accrual and data collection**

Patients were eligible for this study, if they were diagnosed with cancer (any type), 65 years of age or older at the time of their diagnosis, and able to communicate and provide data in English. For the survey portion of the study, patients were approached in the reception area of the ambulatory cancer center while they were waiting for their clinic appointments. The research coordinator explained the study and invited people to participate. Those who consented to participation completed the Cancer Patient Information Importance/Satisfaction Tool[23] and returned it to the coordinator. The survey took between 6 and 10 min to complete.

For the interview portion of the study, a separate sample of individuals was accrued. Individuals were approached in the reception area of the ambulatory cancer center by the research coordinator while they were waiting for their clinic appointments. The research coordinator explained the study and invited participation. Those patients who consented to participation underwent an interview concerning their perspectives about the provision of information during their cancer experience. The interviews were face-to-face and conducted in a private setting away from the reception area. The interviews lasted between 10 and 25 min, and data were recorded by the research coordinator.

**Data collection and instruments**

Survey data were gathered using the Cancer Patient Information Importance/Satisfaction Tool. In addition to demographic data (i.e., gender, age, type of cancer, date of diagnosis), the tool contains 12 items measuring the importance of selected cancer-related information topics and 12 items measuring satisfaction with the information received on the same topics. Two additional items were incorporated into the survey to ask about MyChart (a specific portal that offers access to the patient’s health record) and information related to paying for the cost of medications. Ratings for each item are completed on a 5-point Likert scale (low of 0 to high of 4). The instrument can be used as a checklist, to produce topic or item specific scores, or as a two-scale measure, producing an importance and a satisfaction score. In a mixed group of 540 cancer outpatients, the Cronbach’s alphas were 0.89 for the importance subscale and 0.92 for the satisfaction subscale.

The interview schedule was created for the purposes of this study. The initial questions in the interview elicited patient perspectives about the information they had received following their diagnosis, who had provided the information, and how understandable or helpful the information was for them. The second part of the interview provided an opportunity to explore the individuals’ viewpoints about the availability of information, what sources (i.e., books, internet, brochures, etc.) he or she had used to access information, and how helpful they found each of these sources. The final interview questions focused
on any barriers that had been experienced in the search for information and suggestions the individuals had for future educational approaches for older adults.

**Statistical analysis**

Data were grouped for analysis on the basis of age: 65-79 years (old) and 80 and older (very old). Within each group, descriptive statistics were generated for the demographic variables time since diagnosis, gender, and type of cancer. To answer objective 1 and 2, mean item scores were calculated for each of the importance and satisfaction items and mean total scores were calculated for the importance subscale and the satisfaction subscale. Student's t-test was utilized to answer objective 3. The Statistical Package for the Social Sciences (SPSS version 16.0) was utilized for the analysis.

Interview records were also divided according to the same age groups and subjected to a standard content analysis\[35\] to answer objective 4. The content for each question was treated separately and summarized; subsequently, key ideas for coding categories were identified across all questions. The analysis was completed by the primary author and the research coordinator. Each read the transcripts separately and made marginal notes regarding the key messages or coding categories. The notes were discussed together, and agreement reached on the definitions for the code categories. Final coding was completed by the primary author using the agreed upon code categories.

**Results**

Following the presentation of the demographic information for both samples, the results will be presented for the survey portion of the study followed by the results from the interview sample.

**Sample demographics**

A total of 684 older adults with cancer participated in the survey portion of this study [Table 1a]. One hundred and thirty were 80 years and above. The average age of those in the 65-79 years old group was 71.2 (range: 65-79) while the average in the group of 80 years and above was 82.8 (range: 80-88). Participants ranged from within 1-month of diagnosis to 5.8 years. On average, participants were 2 years since they had been diagnosed. The sample contained individuals across a range of cancer disease types.

| Demographic items | 65-79 years | 80+ years |
|-------------------|-------------|-----------|
| Number in sample  | Male 321    | Male 78   |
|                   | Female 233  | Female 52 |
| Average age (years) | Mean 71.34 | Mean 83.36 |
|                   | Range 65-79 | Range 80-93 |
| Time since diagnosis (months) | Mean 34.16 | Mean 48.00 |
|                   | Range 1-276 | Range 1-132 |
| Diagnosis type    | Breast 4    | Breast 8 |
|                   | Gynecological 38 | — |
|                   | GI 43       | GI 7 |
|                   | GU 142      | GU 23 |
|                   | H and N 31  | H and N 4 |
|                   | Other 90    | Other 29 |

| GI: Gastrointestinal, GU: Genitourinary |

A total of 39 individuals participated in the interview portion of this study [Table 1b]. Eleven were 80 years of age and above. The average age of those in the 65-79 years old group was 71.3 (range: 66-78) while the average in the group of 80 years and above was 82.8 (range: 80-88). Participants ranged from within 1-month of diagnosis to 5.8 years. On average, participants were 2 years since they had been diagnosed. The sample contained individuals across a range of cancer disease types.

| Demographic items | 65-79 years | 80+ years |
|-------------------|-------------|-----------|
| Number in sample  | Male 16     | Male 7   |
|                   | Female 12   | Female 4 |
| Average age (years) | Mean 72.2  | Mean 83.1 |
|                   | Range 66-78 | Range 80-88 |
| Time since diagnosis (months) | Mean 19.8  | Mean 33.1 |
|                   | Range 2-36  | Range 18-66 |
| Diagnosis type    | Breast —    | Breast 3 |
|                   | Gynecological — | — |
|                   | GI 8        | GI 3 |
|                   | GU 4        | GU 1 |
|                   | H and N 2   | H and N 2 |
|                   | Other 2     | Other 3 |

| GI: Gastrointestinal, GU: Genitourinary |
SD = 9.90) and the women (mean = 40.06, SD = 8.59) in the 65-79 years group ($t = 4.86, P < 0.01$).

The total scores for the satisfaction subscale could range from 0 (low) to 48 (high). The mean total scores for satisfaction were 34.08 (SD = 10.70) for 65-79 years group, and 32.37 (SD = 11.02) for 80, and over group [Table 2]. No significant differences were noted in the total mean scores between the groups divided by age or gender.

Item scores for importance could range from 0 (low) to 4 (high). Average item scores for importance ranged from 3.72 to 2.06. Mean scores were highest for the disease, treatment, and side effect items in both age groups [Figure 1]. Lowest mean scores were seen for information about self-help groups and how to speak with another individual who has cancer. No statistically significant differences were noted in the item ratings between the two age groups.

Item scores for satisfaction could range from 0 (low) to 4 (high). Average item scores for satisfaction ranged from 3.51 to 2.07. Mean scores were highest for the disease, treatment and side effect items in both age groups [Figure 2]. Lowest means scores were observed for information about self-help groups and how to speak with an individual who had cancer. No statistically significant differences were noted in the item ratings between the two age groups.

### Perspectives from interviews

Despite the variation in ages, interview participants shared very similar perspectives about accessing cancer information. All indicated they had been given information from their cancer care providers, citing physicians and nurses most frequently. They did not have to ask for basic information and found the information they were given was fairly easy to understand. If they had concerns, they

| Importance and satisfaction total scores ($n = 660$)* |
|------------------------------------------------------|
| Demographic items | Male | Female | Total |
|-------------------|------|--------|-------|
| **Importance rating**  
65-79 years  
$n$ | 310 | 223 | 533 |
| Mean | 36.14 | 40.06 | 37.78 |
| SD | 9.90 | 8.59 | 9.57 |
| 80+ years  
$n$ | 75 | 52 | 127 |
| Mean | 36.79 | 38.52 | 37.50 |
| SD | 9.24 | 11.04 | 10.01 |
| **Satisfaction rating**  
65-79 years  
$n$ | 301 | 221 | 522 |
| Mean | 34.43 | 33.61 | 34.08 |
| SD | 10.62 | 10.82 | 10.70 |
| 80+ years  
$n$ | 73 | 50 | 123 |
| Mean | 32.71 | 31.86 | 32.37 |
| SD | 10.22 | 12.18 | 11.02 |

*Twenty-four (3.5%) of the surveys from the total sample were incomplete. SD: Standard deviation

**Figure 1:** Importance scores by item for two groups of older adult cancer patients.
found they could ask questions and either the physician or nurse would help to clarify information for them. For the most part, participants found the information they received was relevant and helpful, but there were times they wanted more detail and more time to talk in greater depth about information that was specific to their individual situation. Some struggled with the medical language and statistics used by the providers.

When asked about barriers to accessing information or ways in which the provision of information could be improved, participants made several practical suggestions. One of the most frequently expressed comments is captured in the following quote from one participant: “Make it easy to find. Do not make me have to search it out or have to ask for it.” Sometimes individuals did not know where to go in the cancer center for information while others indicated their lack of mobility made it a challenge to walk around and look for information. Having readily available sources of information in the waiting areas of the clinic was seen as useful.

Participants described their conversations with health care providers as frequently “…too fast and full of technical or medical jargon.” They recommended health care professionals needed to think about their language and the speed at which they spoke. It is an emotional time for patients, and they are trying to grapple with information that is new to them. One participant stated: “Take more time with me, get my point of view; take the time to talk and do not be in such a rush.”

Participants also suggested that as much information as possible ought to be written down so that they could take it home with them and read it through later, either by themselves or with their family members. In the words of one participant: “Give me more written information to take home, increase the quantity. I can forget some of the conversation and need to read it and think about it after.” In particular, participants wanted the written information to be specific, simplified, and detailed for their specific situation. One participant stated: “Simplify everything and write it down as though you were writing for a 5-year old.”

Finally, participants spoke about the sources of information they had accessed in addition to speaking with health care professionals and provided a rating of the usefulness of these sources on a 10-point scale [Table 3]. During the interview, all of the females and all but 2 of the males identified health care professionals as the primary source of their information. Beyond health care professionals, the most frequently identified sources of information were seminars at the cancer center (21/39), the Internet (20/39), and pamphlets from the cancer center (19/39). Usefulness scores for each source of information varied widely across the respondents.

**Discussion**

This work was undertaken to understand more about the perspectives of older adults with cancer regarding the provision of cancer-related information. The data were
The older adults in this study rated information as important, but their satisfaction with what is provided varies. The importance they assign to disease and treatment-related topics has been reported in other investigations and is a common perspective across all cancer patient age groups.\[36\]

Utilizing both quantitative and qualitative methods provided helpful insight into the experiences of older adults receiving cancer treatment concerning access and use of cancer-related information. The satisfaction scores indicated a range of perspectives from high to low while the interviews illustrated some of the reasons behind the varied satisfaction ratings. It should be noted the interview sample included individuals who self-selected to be participants. Overall the sample included highly functioning individuals who were not experiencing challenges in terms of English, literacy, eyesight, or hearing. Nonetheless, they still described specific ways improvements could be made to improve the provision of information during the cancer experience. Their comments were focused on very practical ideas with direct implications for clinicians caring for older adults with cancer (i.e., speak more slowly, use less medical jargon, write information down). The older adults suggested that clinicians get to know the person, and his or her unique perspective, so that the information and its presentation could be tailored to the individual. Having a personal conversation was a valued aspect of the interaction with health care professionals as was being treated as an individual. These are all ideas that are in keeping with the tenets of person-centered care and are considered to be aspects of quality cancer care.\[7,37\]

There were no statistically significant differences between the two age groups regarding the ratings for importance and satisfaction except men and women in the 65-79 years old group on importance. This mirrors other reports on gender differences regarding the importance of information and supports recommendations to tailor information delivery for women and men.\[36\] However, it is not clear why the observation did not emerge for the 80 and above age group.

The interview data suggest that older cancer patients are using a variety of sources of information. After talking with health care professionals as the primary source of information, older adults reported group-based programs (seminars, classroom programs), where interaction can occur, were popular. Having access to written materials was also seen as helpful. The use of internet was frequent in this small sample and bears future consideration from a research and evaluation perspective. Given the growth in the use of electronically based media and social network tools, there is an opportunity to develop appropriate age applications.

**Implications**

Although these data were derived from one setting, the implications for practice emerging from this study are clear. Participants provided useful suggestions, especially for cancer nurses to consider in light of the significant proportion of cancer patients who will be in the older age groups in the future.

Cancer nurses need to consider their verbal interactions with older adults and generally think about the speed with which they speak and the choice of language. It is important to ensure the language is user-friendly and understandable rather than being highly populated with medical words. Nurses also need to determine how they can learn quickly about the individual and what is important to that person, and adapt the conversation accordingly. In particular, finding out what the person thinks is important to know, obtaining his or her perspective on relevant topics, and making certain those topics are discussed clearly and in sufficient detail for that person could contribute to patient satisfaction. Furthermore, making use of written materials...
to support any teaching or sharing of information, rather than relying on the verbal conversation alone, will be useful to the older patient. The patient can take the material home, review it as necessary, and share it with their family members.

As for patient education programs, there are implications from this study as well. One of the main suggestions from patients was to make information easily available and in written form. Having pamphlets and posted materials within a cancer facility, clearly visible, means that older adults do not have to walk distances to access materials. Clearly, individuals have specific preferences for different types of formats and sources. Having a choice of formats (i.e., written, video, audio tapes, etc.) would be useful. Clear signage about where materials are located and where older patients can access resources is imperative.

Future exploration might be helpful to determine whether cancer nurses would like support in their interactions with older adults. Investigating current practices of cancer nurses in providing information to older cancer patients, the resources they currently use, and the skill level they possess in patient education delivery could provide a basis for determining how best to support them. It may be helpful to consider offering staff nurses educational programs about the learning needs of older adults and the best approaches to use in teaching this population. Such educational programs for nurses could augment their existing competencies by engaging them in coaching activities surrounding effective communication or patient teaching approaches. Providing appropriate written materials for nurses to give to patients during a conversation with the older cancer patient would also be beneficial.

Finally, this work could be replicated in other cancer centers. The Cancer Patient Information Importance/Satisfaction Tool exists in both English and French, but could also be translated into other languages for use in other countries. The anticipated growth in older cancer patient populations in various parts of the world raises questions about their needs for cancer-related information and how best to provide that information to be culturally and age appropriate.

References

1. Fitch MI, Page B, Porter HP. Supportive Care Framework: A Foundation for Person-centered Care. Pembroke, ON: Pappin Communications; 2008.
2. Fitch MI, Gray RE, Godel R, Labrecque M. Young women’s experiences with breast cancer: an imperative for tailored information and support. Can Oncol Nurs J 2008;18:74-86.
3. Fitch MI, Mings D, Lee A. Exploring patient initiated strategies for living with treatment induced fatigue. Can Oncol Nurs J 2008;18:124-40.
4. Fitch MI, Nicoll I, Keller-Olaman S. Breast cancer information dissemination strategies — Finding out what works. Can Oncol Nurs J 2007;17:206-10.
5. Steele R, Fitch MI. Supportive care needs of women with gynecologic cancer. Cancer Nurs 2008;31:284-91.
6. Vloosak D, Fitch MI. Multiple myeloma: The patient’s perspective. Can Oncol Nurs J 2008;18:141-51.
7. Accreditation Canada. Standards: Cancer Care and Oncology Services. Ottawa: Accreditation Canada; 2010.
8. Manning DL, Dickens C. Cancer Information and Support Centres: fixing parts cancer drugs cannot reach. Eur J Cancer Care (Engl) 2007;16:33-8.
9. Canadian Cancer Society. Canadian Cancer Statistics 2012. Toronto: Canadian Cancer Society; 2012.
10. Ebersole P, Hess P, Touhy T, Jett K. Gerontological Nursing and Healthy Aging. 2nd ed. St. Louis, MO: Mosby; 2005.
11. Rutten LJ, Arora NK, Bakos AD, Aziz N, Rowland J. Information needs and sources of information among cancer patients: A systematic review of research [1980-2003]. Patient Educ Couns 2005;57:250-61.
12. van der Molen B. Relating information-needs to the cancer experience 1. Jenny’s story: A cancer narrative. Eur J Cancer Care (Engl) 2000;9:41-7.
13. Skalla KA, Bakitas M, Furstenberg CT, Ahles T, Henderson JV. Patients’ need for information about cancer therapy. Oncol Nurs Forum 2004;31:313-9.
14. Coulter A. When should you involve patients in treatment decisions? Br J Gen Pract 2007;57:771-2.
15. Mills ME, Davidson R. Cancer patients’ sources of information: use and quality issues. Psychooncology 2002;11:371-8.
16. Schofield P, Jefford M, Carey M, Thomson K, Evans M, Baravelli C, et al. Preparing patients for threatening medical treatments: Effects of a chemotherapy educational DVD on anxiety, unmet needs, and self-efficacy. Support Care Cancer 2008;16:37-45.
17. Davidson JR, Brundage MD, Feldman-Stewart D. Lung cancer treatment decisions: Patients’ desires for participation and information. Psychooncology 1999;8:511-20.
18. Sutherland G, Dpsyeh LH, White V, Jefford M, Hegarty S. How does a cancer education program impact on people with cancer and their family and friends? J Cancer Educ 2008;23:126-32.
19. Gray RE, Fitch M, Greenberg M, Hampson A, Doherty M, Labrecque M. The information needs of well, longer-term survivors of breast cancer. Patient Educ Couns 1998;33:245-55.
20. Gulavita S, Sinnott C, Setliff AE, Sellick SM. Short report: What do men with prostate cancer want to know? Can Fam Physician 2000;46:1769-71.
21. Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. BMJ 2004;328:1343.
22. Smith C, Dickens C, Edwards S. Provision of information for cancer patients: An appraisal and review. Eur J Cancer Care (Engl) 2005;14:282-8.
23. Fitch MI, McAndrew A. A performance measurement tool for cancer patient information and satisfaction. J Cancer Educ 2011;26:612-6.
24. Leyton GM, Boulton M, Moynihan C, James A, Mossman J, Boudioni M, et al. Cancer patients’ information needs and information seeking behavior: In-depth interview study. Br Med J 2000;320:909-13.

25. Hughes LC, Hodgson NA, Muller P, Robinson LA, McCorkle R. Information needs of elderly postsurgical cancer patients during the transition from hospital to home. J Nurs Scholarsh 2000;32:25-30.

26. Kessels RP. Patients’ memory for medical information. J R Soc Med 2003;96:219-22.

27. Montgomery C, Lydon A, Lloyd K. Psychological distress among cancer patients and informed consent. J Psychosom Res 1999;46:241-5.

28. Stewart MA. Effective physician-patient communication and health outcomes: A review. CMAJ 1995;152:1423-33.

29. Fitch MI, Green E. Measuring patient satisfaction across the cancer system. Support Cancer Care 2005;13:472.

30. MacCourt P, Wilson K, Kortes-Miller K, Gibson M, Fitch M. Promoting seniors mental health in cancer care: A guide for front-line health care providers. Vancouver, British Columbia: British Columbia Psychogeriatric Association; 2008.

31. O’Connell JB, Maggard MA, Ko CY. Cancer-directed surgery for localized disease: Decreased use in the elderly. Ann Surg Oncol 2004;11:962-9.

32. Tallarico M, Figueiredo M, Goodman M, Kreling B, Mandelblatt J. Psychosocial determinants and outcomes of chemotherapy in older women with breast cancer: What do we know? What do we need to know? Cancer J 2005;11:518-28.

33. Mor V, Allen S, Malin M. The psychosocial impact of cancer on older versus younger patients and their families. Cancer 1994;74:7 Suppl:2118-27.

34. Kelner M. Activists and delegators: Elderly patients’ preferences about control at the end of life. Soc Sci Med 1995;41:537-45.

35. Charmian K. Grounded theory: Objectivist and constructivist methods. In: Denzin NK, Lincoln YS, editors. Handbook of Qualitative Research. 2nd ed. Thousand Oaks, CA: Sage Publications; 2000. p. 599-35.

36. Fitch MI, McAndrew A, Harth T. Measuring trends in performance across time: Providing information to cancer patients. Can Oncol Nurs J 2013;23:247-61.

37. Adler NE, Page AE, editors. Institute of Medicine. Cancer Care for the Whole Person: Meeting Psychosocial Health Needs. Washington, DC: The National Academies Press; 2008.

How to cite this article: Fitch MI, McAndrew A, Harth T. Perspectives from older adults receiving cancer treatment about the cancer-related information they receive. Asia Pac J Oncol Nurs 2015;2:160-8.

Source of Support: Nil. Conflicts of Interest: None declared.