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EARLY WARNING OF CANCER
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Pre-disclosure of cancer in general practice: A key stage in patient management

INTRODUCTION

The disclosure of a cancer diagnosis is a key stage in the care pathway for patients with cancer[1,2] . The experience of this disclosure is often difficult for patients[3,4] . The disclosure of a cancer diagnosis has been formalised in France since the development of the first Cancer Plan (2003–2007): the Disclosure Framework (DA)[5] . This institutional framework provides a structure for the communication of a cancer diagnosis so that patients can receive information, be listened to and receive support under the best possible conditions. Since January 2006, this DA has been rolled out across all cancer centres in France. However, coordination between hospital teams and local GPs needs to be strengthened[5,6] .

The diagnosis of cancer is not delivered by a single doctor on a single occasion, as the 'medical timeframe' of the DA – long associated solely with the 'diagnosis consultation' – might suggest. It is a fragmented process, spread out over time and across different healthcare professionals, which must take into account the patient's knowledge and understanding[7,8] . The first mention of the disease may take place in a general practice setting, prior to the specialist consultation, by non-oncologists and particularly GPs[3,9] . This calls into question the role of the GP in the specialist consultation and their involvement in preparing the patient for the cancer diagnosis. GPs, as primary care physicians, are involved in the prevention, screening and sometimes diagnosis of cancers[10] . They can be regarded as 'catalysts' for the cancer disclosure, as they are on the front line when the disease is suspected. The disclosure consultation with the specialist is rarely the starting point, but rather the culmination of a multiprofessional care pathway initiated in the community, prior to the diagnosis, and for which the GP is often the coordinator.

GPs have identified three phases in their practice: the pre-disclosure phase (), the disclosure phase, and the post-disclosure phase of cancer[11] . We have therefore defined the pre-disclosure as the moment when the GP, during the patient's diagnostic journey, first raises the possibility of cancer with the aim of preparing the patient for this eventuality, without necessarily having a formal diagnosis. This pre-disclosure is a vague stage for which there is currently no established framework. Few studies have focused solely on this phase of the disclosure process[11] . Beyond practical experience in the field, knowledge is limited regarding how GPs organise the pre-disclosure, how it unfolds, and the difficulties encountered.

The main objective of this study was to examine the process and content of cancer screening carried out by GPs. The secondary objectives were to examine the approaches to screening already adopted by GPs; and to identify the difficulties encountered and the reasons why screening was not carried out.

MATERIALS AND METHODS

This retrospective, observational study assessed the professional practices of general practitioners who had a registered patient referred for a diagnosis disclosure consultation at the IUCT-O (Toulouse University Cancer Institute – Oncopôle). A quantitative method was chosen to assess the frequency with which the pre-disclosure was carried out and the frequency of the topics explored.

The questionnaire

A literature review was conducted using the PubMed, EM Premium and Google Scholar databases, as well as French repositories (the Haute Autorité de Santé and the Institut National du Cancer). The keywords used for this search were: general practitioner, pre-disclosure, disclosure, diagnosis, cancer. The questionnaire was developed based on data from the literature[5,7,9,11] , which was drawn primarily from articles on cancer disclosure.

The questionnaire was divided into six sections: [1] the epidemiological characteristics of the doctors; [2] whether the health assessment had been carried out; [3] the conduct of the health assessment; [4] its content; [5] the difficulties encountered; and [6] the tools to be developed to assist GPs during this consultation. It comprised 32 closed-ended questions and one open-ended question (Appendix 1). Doctors who had not carried out a pre-disclosure were not asked about sections [3], [4] and [5] of the questionnaire and answered 16 questions. Doctors who had carried out the pre-disclosure were not asked about the end of section [2] and were required to answer 30 questions. The questionnaire was anonymised. It was tested with six GPs to assess its feasibility, relevance and completion time. Following revisions, it was made available online via the *Google Forms*© application.

Selection of patient records

ICD-10 (International Classification of Diseases) coding was applied to data from the medical information department of the Toulouse University Cancer Institute (France). This enabled the selection of records for patients who had been diagnosed with cancer between 1 October and 31 December 2017. The characteristics of the patients were recorded.

The inclusion criteria for patient records (PRs) were:

- Adult patients with solid or haematological cancer,
- Cancer-related admissions occurring between 1 October and 31 December 2017.

The exclusion criteria were:
- Patients who had previously undergone cancer surgery,
- Patients who, upon retrospective review, were found not to have cancer,- Patients unable to give free and informed consent (minors, patients with mental or cognitive disorders, and patients who had died at the time of case selection),- Patients whose medical records were incomplete,
- Patients who were their own GP or whose GP was a family member,
- Patients whose GP had already been included in the study.

Following this stage, the administrative data from the selected patient records enabled us to contact them by telephone to obtain their verbal consent to their inclusion and to the request that would be made to their GP.

Following this telephone contact, the following patients were excluded:

- those refusing to take part in the study,
- those who could not be reached by telephone after three unsuccessful calls,
- treatment abroad.

Recruitment of GPs

The questionnaire was sent to GPs whose patients had agreed to take part in the study.

Initially, the questionnaire was sent to the patient's registered GP via secure email. If no reply was received within seven days, a telephone call was made. Following this call, and provided the GP had given their consent, the questionnaire was returned via the method chosen by the doctor: secure email, fax or post. If there was no response, the email was sent twice before a final telephone call was made. GPs who had not responded within one month of the last reminder were considered non-responders.

In total, GPs were excluded if they:
- had refused to take part in the study,
- could not be contacted,
- remained non-responders after follow-up attempts.

Data analysis

Data collection took place between 1December 2017 and 31 March 2018, via post and fax. The data were then analysed using *Microsoft Excelmac2011*© and the INSERM **BiostaTGV**© website. Socio-demographic characteristics and variables of interest were described in terms of numbers and percentages for quantitative variables. In order to compare the qualitative variables according to anticipation of the pre-disclosure, the duration of the pre-disclosure and the use of the word 'cancer', a chi-squared test was carried out, or Fisher's exact test where the former was not applicable (theoretical sample sizes of less than 5). The alpha significance level used for these tests was 0.05.

Regulatory aspects

This study was conducted outside the scope of the Jardé Act. The Ethics Committee of the University Department of General Practice in Toulouse issued a favourable opinion regarding the conduct of this study on 12 August 2017, No. 2017-014 (Appendix 2). A compliance application was submitted to the CNIL via Reference Method No. 3, requesting oral consent from patients and GPs for their participation in the study: No. 2081263 v 0 (Appendix 2).

RESULTS

Between 1 October and 31 December 2017, 555 cases of cancer were recorded, and we received 81 responses from GPs (Figure 1), 82.7% of whom had seen their patients in consultation prior to the diagnosis being confirmed. Of the 81 patients included, 61.7% (n = 50) were women. The mean age was 56.3 years, with a median of 58 years. The three most common cancers among women were breast cancer, haematological cancers and thyroid cancer. For men, the most common were ENT cancers, haematological cancers and testicular cancer. The GP characteristics are detailed in Appendix 3. The 81 GPs had been in practice for an average of 21 years (SD: 11.3 years) and had been treating their patients for more than 10 years in 44.4% of cases. 74.1% (n = 60) of them practised in a group practice or a multi-professional health centre.

Planning for the Pa

A cancer screening test was carried out in two-thirds of cases and had been anticipated by 75.9% of GPs (n = 41/54) (Table 1). Of the doctors preparing for this consultation, 68.0% had considered how to broach the possibility of cancer. When GPs specifically researched the treatment and prognosis of the disease, consultations were significantly longer, lasting more than 30 minutes ($p < 0.01$ and $p = 0.03$) (Table 2). GPs who had planned for palliative care were more likely to discuss supportive care and the adverse effects of treatments with their patients ($p = 0.07$ and $p = 0.08$). Having a histological diagnosis did not appear to influence the anticipation of the pre-disclosure (46.3% versus 30.8%, $p = 0.32$) (Table 2).

The palliative care consultation lasted more than 15 minutes in 88.9% (n = 48) of cases and more than 30 minutes in 25.9% (n = 14) of cases (Table 1). The duration of the consultation was not influenced by the type of topics discussed, nor by the decision to withhold certain information during the consultation. During these consultations, 81.5% of doctors sought to find out what their patients already knew about their health condition and 87.0% asked what they wanted to know. The two most frequently discussed topics were cancer treatment and supportive care (Table 2).

The content of the Pa

The word 'cancer' was mentioned in 70.4% of the pre-disclosure consultation. It was mentioned by more than three-quarters of GPs who had planned the pre-disclosure consultation and by half of those who had not (Table 2). Having the histological diagnosis did not influence the perception that the doctor was withholding information.

Over 80% of GPs were in favour of limiting information to give the patient hope, to conduct the pre-disclosure in several stages, and to avoid overwhelming the patient with information (Figure 2). GPs suggested a follow-up consultation after this pre-disclosure in 68.5% of cases. This approach to care made it possible to plan the pre-disclosure in advance ($p = 0.01$), to increase the consultation time to over 30 minutes (p = 0.01) and to use the word 'cancer' more frequently ($p = 0.03$) (Table 2).

CONDUCT OF THE PRE-DISCLOSURE		
	N = 54	*(%)*
Early pre-disclosure:	41	*(75.9)*
Duration of consultation (min):		
< 15	6	*(11.1)*
15 to 30	34	*(63.0)*
> 30	14	*(25.9)*
Patient accompanied by a family member	20	*(37.0)*
Preliminary notification given:		
After the discovery of a suspicious clinical sign	31	*(57.4)*
Following an abnormal screening test	15	*(27.8)*
Following an abnormal follow-up test	42	*(77.8)*
After the biopsy was performed	25	*(46.3)*
After receiving the pathology report	23	*(42.6)*
At the request of a colleague	2	(3.7)

Table 1 - Description of the pre-disclosure

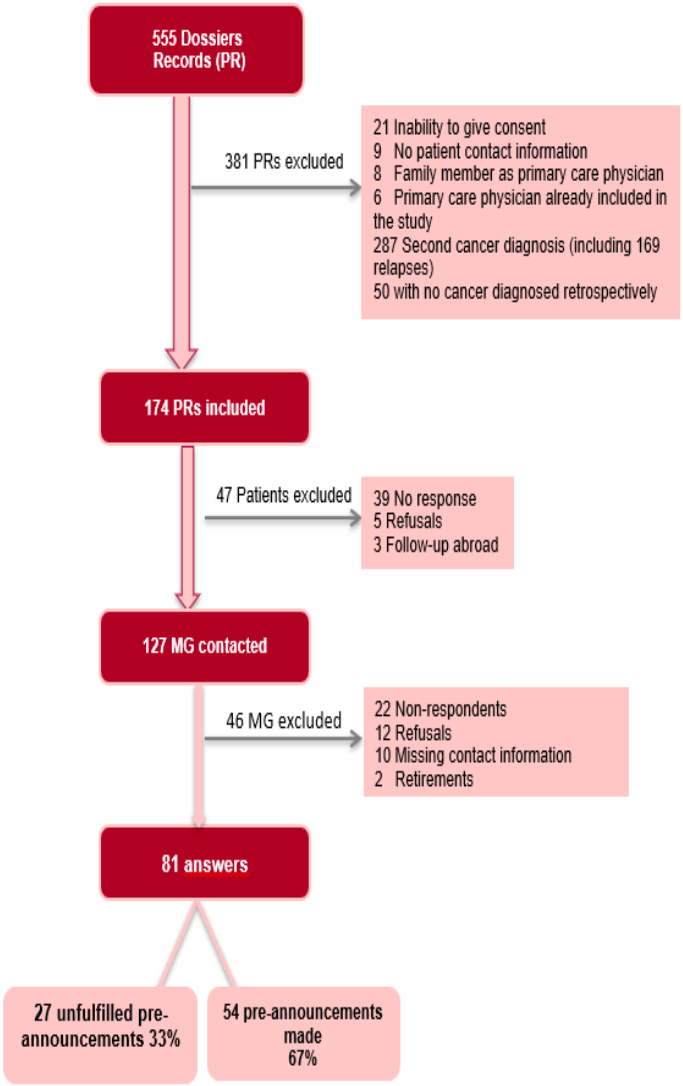

Table 1 - Flowchart

Challenges and benefits of pre-disclosure

The pre-disclosure did not present any difficulties for 20.4% (n = 11) of GPs. For the others, the difficulties were due to a lack of prognostic information (66.7%), therapeutic information (64.8%), diagnostic uncertainty (27.8%) and emotional distress. GPs most often sought information by consulting specialist colleagues (75.3%) or by referring to online resources (70.4%). Seventy-nine percent of doctors would like to have access to additional oncological information resources, and 56.8% were interested in training on palliative care.

For 98.1% of GPs, the pre-disclosure had been helpful in their patient's acceptance of the illness, and 94.5% felt it had played an important role in the overall process of informing their patient of their cancer. 82.7% (n = 67) of GPs were in favour of systematically incorporating a pre-disclosure into the cancer diagnosis process. One third of GPs (n = 27/81) did not carry out the pre-disclosure, although 48.1% (n = 13/27) would have liked to. The most common reason for not carrying it out (51.8%, n = 14) was related to feasibility, as the patient had not been seen in a GP consultation prior to diagnosis. 29.6% of GPs (n = 8) had not discussed the suspected cancer diagnosis because pathological results were not yet available at the time of the consultation (Figure 3). None of the GP characteristics or the type of cancer contributed to the conduct of the pre-disclosure consultation.

DISCUSSION

Two-thirds of GPs had raised the possibility of cancer with the patient prior to the Disclosure Procedure (DP). Three-quarters of GPs had prepared for this consultation. GPs who prepared for the pre-disclosure by seeking information on the treatment and prognosis of the disease had significantly longer consultations ($p < 0.05$). Planning to see the patient again was associated with a comprehensive pre-disclosure consultation: one that was lengthy, scheduled in advance, and during which the word 'cancer' had been mentioned. The more GPs felt involved in their patient's cancer diagnosis, the more they invested in the pre-disclosure process ($p < 0.01$).

Strengths and limitations

The main strength of this study lies in its originality. To

	Anticipation of the Preliminary Announcement (Pa) (N = 54):						
	Anticipation (N = 41)		No Anticipation (N = 13)		Total (N = 54)		*p*
	N	*(%)*	N	*(%)*	N	*(%)*	
Topics covered during the practical session:							
Treatments	35	*(85.4)*	9	*(69.2)*	44	*(81.5)*	0.23[F]
Stage of cancer	12	*(29.3)*	2	*(15.4)*	14	*(25.9)*	0.47[F]
Prediction	17	*(41.5)*	4	*(30.8)*	21	*(38.9)*	0.49[C]
Supportive care	21	*(51.2)*	3	*(23.1)*	24	*(44.4)*	0.07[C]
Adverse effects of treatments	15	*(36.6)*	1	*(7.7)*	16	*(26.6)*	0.08[F]
Consultation duration < 30 mins	28	*(68.3)*	12	*(92.3)*	40	*(74.1)*	0.14 [F]
Final diagnosis following histopathological findings	19	*(46.3)*	4	*(30.8)*	23	*(42.6)*	0.32[C]
Performed following abnormal follow-up examination	34	*(82.9)*	8	*(61.5)*	42	*(77.8)*	0.10[C]
Pronunciation of the word 'cancer'	31	*(76.6)*	7	*(53.9)*	38	*(70.4)*	0.17[F]
Knowing what the patient already knew	32	*(78)*	12	*(92.3)*	44	*(81.5)*	0.42[F]
Knowing what the patient wanted to know	35	*(85.4)*	12	*(92.3)*	47	*(87.0)*	1.00[F]
Information provided to the patient	2	*(4.9)*	0	*(0)*	2	*(3.7)*	0.23[F]
Believe they have answered the patient's questions	21	*(51.2)*	6	*(46.1)*	27	*(50.0)*	0.75[C]
Appointment booked remotely	30	*(73.2)*	5	*(38.5)*	35	*(64.8)*	**0.04**[F]
	Duration of Pa (if Pa was anticipated):						
	< 30 mins, (N = 28)		> 30 mins, (N = 13)		(N = 41)		*p*
Before the consultation, did you:							
- Thought about how to approach the diagnosis	18	*(64.3)*	10	*(76.9)*	28	*(68.3)*	0.49[F]
-Has researched treatments	4	*(14.3)*	9	*(69.2)*	13	*(31.7)*	**<0.01**[F]
-Has carried out research into prognosis	5	*(17.8)*	7	*(53.8)*	12	*(29.3)*	**0.03**[F]
-Sought specialist advice	6	*(21.4)*	3	*(23.1)*	9	*(22.0)*	1.00[F]
	Pronunciation of the word 'Cancer':						
	Pronounced (N=38)		Not pronounced (N = 16)		Total (n=54)		*p*
Completed after:							
an abnormal clinical sign	24	*(63.2)*	7	*(43.8)*	31	*(57.4)*	0.18[C]
An abnormal screening result	12	*(31.6)*	3	*(18.8)*	15	*(27.8)*	0.50[F]
An abnormal follow-up examination	30	*(78.9)*	12	*(75)*	42	*(77.8)*	0.70[F]
Performing a biopsy	21	*(55.3)*	4	*(25)*	25	*(46.3)*	0.07[F]
Pathology	18	*(47.3)*	5	*(31.3)*	23	*(42.6)*	0.27[C]
A request from a colleague	2	*(5.3)*	0	*(0)*	2	*(3.7)*	1.00[F]
Scheduled consultation with Pa	31	*(81.6)*	10	*(62.5)*	41	*(75.9)*	0.17[F]
Remote appointments	28	*(73.7)*	7	*(43.8)*	35	(64.8)	**0.03**[C]
Consultation duration < 30 mins	26	*(65)*	14	*(87.5)*	40	*(74.1)*	0.18[F]

Table 2 - Characteristics of the pre-disclosure (Pa) according to its duration, how far in advance it was given, and whether the word 'cancer' was mentioned. [F]= Fisher's test; [C]= Chi-squared test; p**<0.05** = significant result; Pa = pre-disclosure

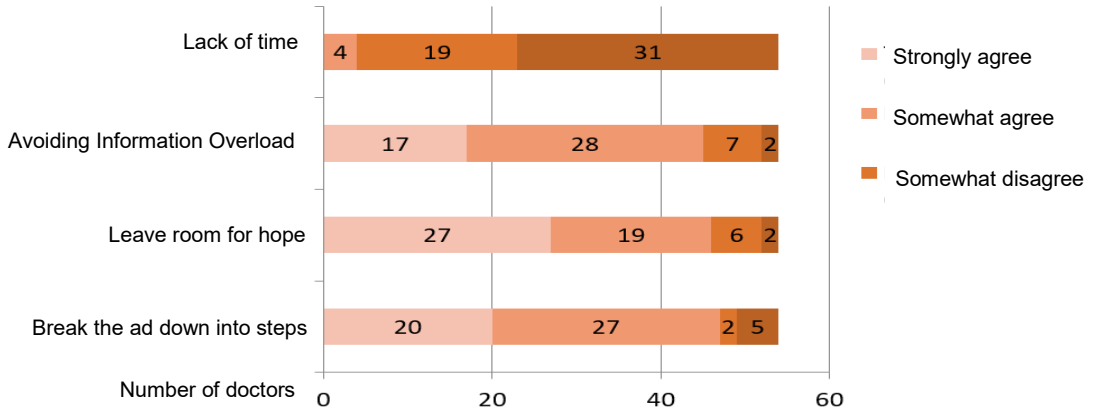

Figure 2 - General Practitioners' Views on the Reasons for Restricting Information Provided to Patients During the Pre-Disclosure Phase

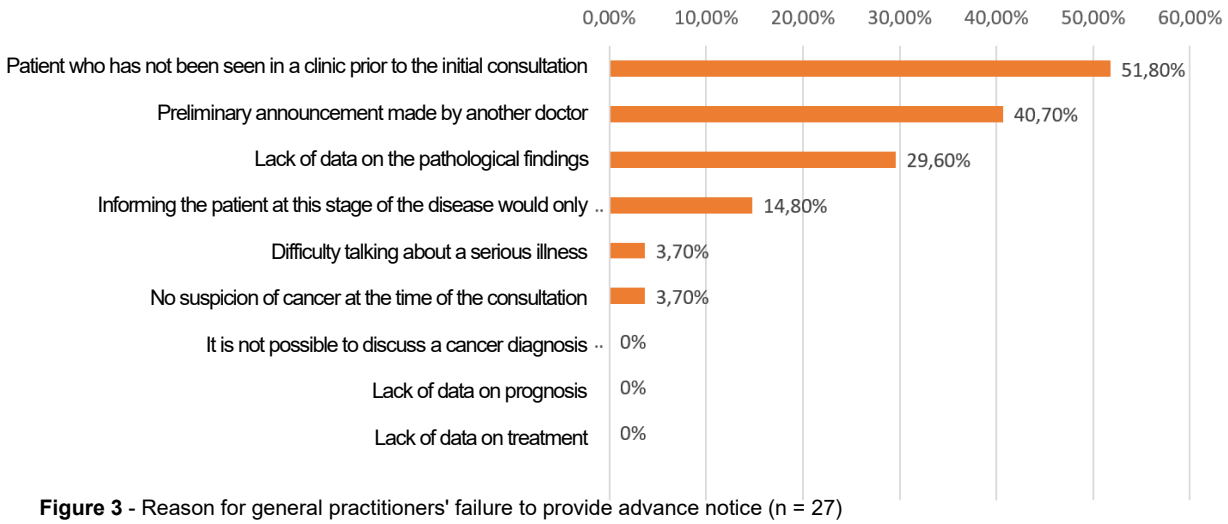

Figure 3 - Reason for general practitioners' failure to provide advance notice (n = 27)

the best of our knowledge, no other study has focused exclusively on this 'pre-disclosure phase of cancer in general practice. Our study, being descriptive in nature, provides an overview of the current situation, enabling a better understanding of GPs' practices. The 63% response rate is very satisfactory, due to the recruitment methods: a doctor contacting GPs by telephone and asking GPs about a patient from their own practice. This method enabled us to minimise recruitment bias and recall bias among GPs. The latter was also reduced by the short interval between the consultation during which the diagnosis was disclosed and patient recruitment.

We chose the IUCT-O for patient recruitment as it is one of the leading cancer centres in our region. A selection bias exists due to the single-centre nature of the study. The median age of patients at the time of diagnosis was 12 years younger than the median age in France in 2023 (70 years) [12] . This difference can be explained by the different types of cancer found in our sample. Certain cancers that are relatively common in our population, such as thyroid cancer (8.6 per cent), testicular cancer (4.9 per cent) and sarcomas (4.9 per cent), are diagnosed at a young age, whereas colon and lung cancers are under-represented.

The patient's care pathway

In our study, 82.7% of GPs surveyed had seen their patient in consultation prior to the cancer diagnosis being announced. GPs contribute to the screening and diagnosis of cancers and to the coordination of the care pathway. This involvement promotes better use of available resources for patients with cancer, notably a reduction in the use of A&E departments and improved access to supportive care[6,13,14] , and falls entirely within their remit[15] . In order to improve coordination, GPs must be involved in the patient's diagnostic pathway through their participation in the cancer care pathway[16] . This early and systematic involvement of GPs would improve patient support and the implementation of the diagnostic process.94.5% of the GPs surveyed in our study felt they had played an important role in the overall diagnosis of cancer. GPs are involved in the diagnostic pathway for patients with cancer[17] . They are consulted by their patients or colleagues beforehand (pre-disclosure), afterwards (post-disclosure), during the disclosure itself and sometimes during the multidisciplinary team (MDT) meeting[11,18] . For patients, the diagnostic pathway can sometimes be unclear and complex[19] . Most patients consult their GP within a week of the diagnosis consultation[11] and the importance of a post-diagnosis consultation has been recognised in France since 2017. GPs have access to a wealth of medical, social and psychological information about their patients, enabling them to act as care coordinators with other specialists[18,20] . The development of pre-disclosure could be beneficial in integrating the patient at an early stage into the diagnostic and subsequent care pathway. This would help strengthen the partnership between specialists and GPs in order to avoid unnecessary consultations or visits to A&E[6] . This approach is therefore likely to improve coordination between community and hospital settings and the quality of care[21] .

Advance notification

We can describe the pre-disclosure as a lengthy consultation, during which doctors assess the patient's fears and expectations. They may limit the information provided in order not to overwhelm the patient, to give them hope, and to conduct a phased pre-disclosure. This consultation is longer than the average for French GPs (16.4 minutes), which is already long by international standards[22]. This allows for taking 'the necessary time' recommended when addressing a serious illness[7] . Breaking the disclosure down into stages so as not to overestimate the patient's capacity to process the information and gradually leading them towards the diagnosis is a recognised communication approach for serious illnesses[3,23] . It would be necessary to establish a structured method to guide the doctor in this communication, considering the patient's emotional reaction, which has already been factored into the delivery of the news. This requires active and empathetic listening to support the patient in coming to terms with the illness[23] . In our study, anticipating the patient's emotional response enriches the content of the communication and enables patients to be included in a care pathway by offering them follow-up care (p = 0.04). This helps to build a relationship of trust and

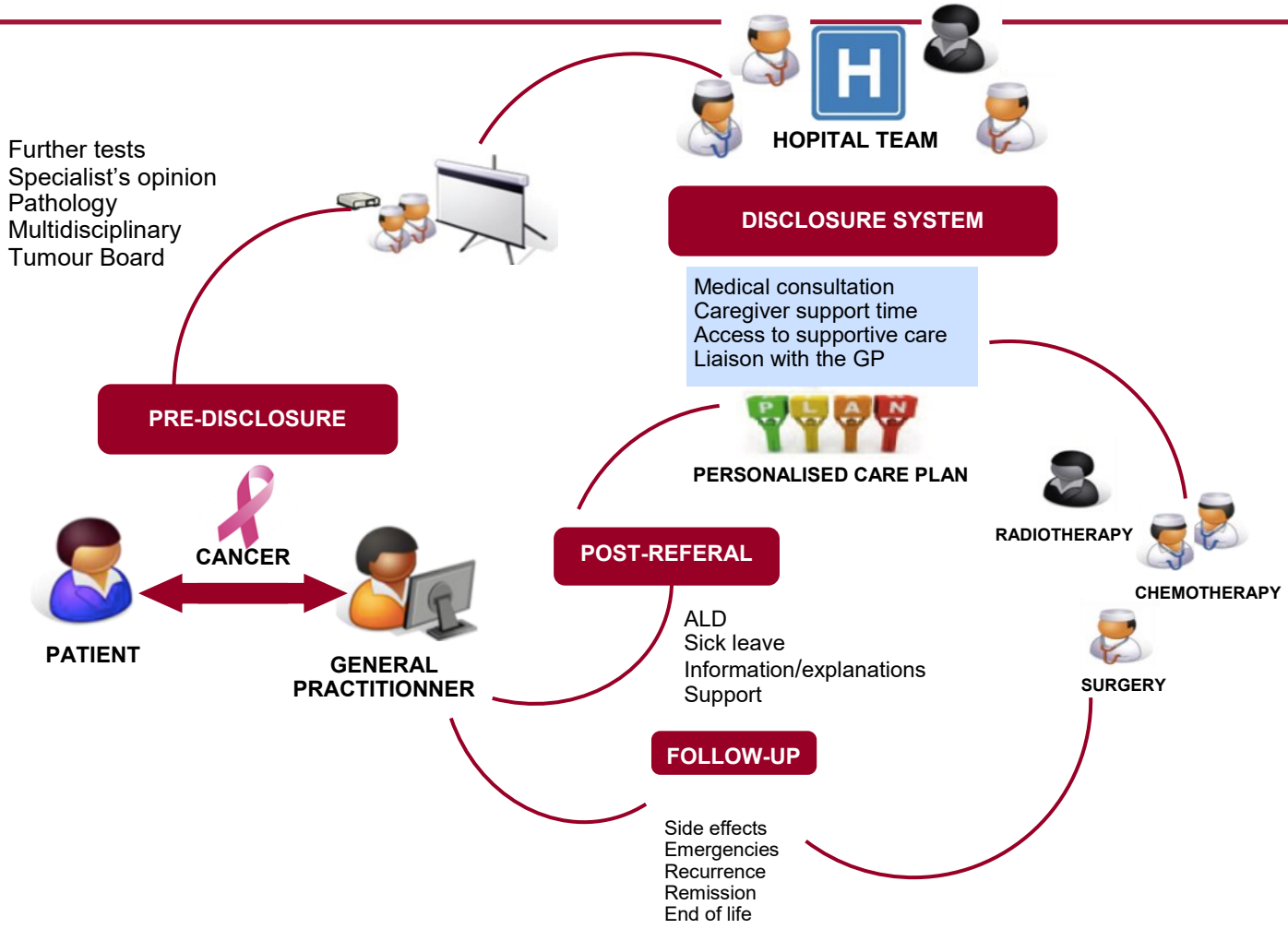

Figure 4 - The role of the preliminary diagnosis by the GP in the overall cancer diagnosis

ongoing support for the patient, guiding them through the various stages of their diagnosis.

During the initial consultation, GPs feel at a loss due to the lack of prognostic and therapeutic information regarding the disease. They feel isolated in their role as primary care providers [24] . The GP plays a central role in the overall cancer disclosure process; their role begins prior to the disclosure, with the pre-disclosure consultation, continues after the diagnosis during the post-disclosure phase, and, of course, throughout the patient's care (Figure 4).

CONCLUSION

Our study highlights the importance of the 'pre-disclosure' of cancer, carried out by two-thirds of GPs. This is an essential but poorly structured stage of the care pathway. Three-quarters of GPs carry out the 'pre-disclosure' and approach it with preparation and commitment. They plan the content in advance and take their time, particularly when follow-up is anticipated. However, difficulties persist, notably due to a lack of information on prognosis and treatment, as well as GPs' sense of isolation in this role. The existence of a standardised pre-disclosure consultation, included in the diagnosis process, would facilitate a smoother diagnostic pathway for patients and ensure consistency in care. . Structuring this consultation, with appropriate tools and enhanced support for GPs, would foster a more calm and gradual dialogue with patients. By strengthening training and developing specific resources, it would be possible to optimise this key phase, leading to more humane and efficient care.

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Conflicts of interest: All authors have declared on the ICMJE form all their links or potential conflicts of interest (financial activities, links with companies or institutions) relating to the submitted work. They declare no conflicts of interest.

Abstract

Background. The diagnosis of cancer is communicated to a patient during a consultation designed to deliver the news, which incorporates a structured timeline and a multidisciplinary approach. However, prior to the start of oncological care, the patient will need to consult their general practitioner (GP). The GP is involved in the early stages of the diagnostic pathway, carrying out screening, identifying symptoms and coordinating the pathway. This consultation prior to the diagnosis, known as the 'pre-disclosure consultation, has been little studied. Objective: To determine the content of the 'pre-disclosure' consultation carried out by GPs in practice.

Method. A retrospective quantitative study was conducted using a questionnaire among GPs who referred patients who had a cancer disclosure consultation between 1 October and 31 December 2017 in Toulouse, France. The online questionnaire comprised 34 closed-ended questions and one open-ended question. Data analysis was descriptive.

Results. Of the 174 patient records selected, corresponding to 174 different GPs, 81 GPs responded. Fifty-four had carried out a 'pre-disclosure' consultation (89% lasting more than 15 minutes, 26% more than 30 minutes). Half mentioned supportive care; almost all considered it helpful for coming to terms with the illness, and 85 per cent limited the information in order to deliver the news in stages. Conversely, 27 of the GPs had not given a 'pre-disclosure', half of whom would have liked to have done so

Conclusion. The 'pre-disclosure' is carried out informally. GPs take the time to organise this consultation and tailor it to the patient. However, a lack of information and the isolation of GPs complicate the 'pre-disclosure'. Integrating it into the disclosure process could improve the coordination of care. Structuring the 'pre-disclosure' using appropriate tools and providing better support for GPs is necessary to support patients.

Keywords. General Practice, Cancer, Disclosure

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APPENDIX 1 - QUESTIONNAIRE FOR GENERAL PRACTITIONERS

PATIENT IDENTIFICATION NUMBER:

GENERAL CHARACTERISTICS: EPIDEMIOLOGY

1-You are:
A man □ A woman □
2-What is your year of birth? (Years)
...
3-Do you practise in a:
Rural □ Semi-rural □ Urban □

4- In which year did you set up your practice?
…
5- Do you practise in a practice:
On your own □
In a group practice □
In a multidisciplinary health centre (MSP) □

6-Do you hold any additional qualification(s) in:
Oncology □ Palliative care □
Pain management □ None of the above three □

If so, what type:
DU □ DESC □ Certificate □

7- How long have you been treating this patient?
0–5 years □ 6–10 years □ >10 years □

8- Do you consider that you played a part in your patient's cancer diagnosis?
Yes □ No □

PRE-DIAGNOSIS: THE SUSPICION OF CANCER:

We define the 'pre-disclosure' of cancer as:
The moment when you discuss the possibility of cancer with your patient in order to prepare them for this eventuality prior to the 'diagnosis consultation', whether the diagnosis is hypothetical or confirmed.

1- Did you discuss the possibility of cancer with your patient before they saw the specialist for the diagnosis consultation (oncologist, surgeon)?
Yes □ No □

If you tick YES, go straight to Part III of the questionnaire. Otherwise, continue.

2- You did not raise this possibility with this patient because:

Tick the options that you consider most relevant.

3- Would you have liked to prepare the patient for this news before they saw the specialist?
Yes □ No □

You may proceed directly to Part VI of the questionnaire, without completing pages III, IV and V.

PRE-DISCLOSURE: PROCEDURE / CONTEXT

1- Had you planned to discuss the possibility of cancer during the consultation?
Yes □ No □

2- How long did this consultation last?
- Less than 15 minutes or so □
-Between 15 and 30 minutes □
-More than 30 minutes or so □

3- Was the patient accompanied by one or more people?
Yes ☐ No ☐
If so, who:
Family ☐ Friend ☐ Healthcare staff ☐ Other(s): …

4- Before this consultation, did you:

	YES	NO
Thought about how to deal with this diagnosis		
Researched the proposed treatments		
Researched the prognosis		
Sought a specialist's advice on management		

5-Did you give this preliminary notice:

	YES	NO
After the discovery of a suspicious clinical sign		
Following an abnormal screening test (population-based or individual)		
Following an abnormal follow-up test (imaging, laboratory tests)		
Following a biopsy		
Following receipt of the pathological report confirming the diagnosis of cancer		
At the request of a colleague		

IV. PRELIMINARY NOTIFICATION: CONTENTS

1- Have you tried to find out:

- What the patient already knew about their condition?
Yes ☐ No ☐

- What they wanted to know about their health?
Yes ☐ No ☐

2- Did you use the word 'cancer'?
Yes ☐ No ☐

3- Did you deliberately withhold certain information in order to:

	Strongly agree	So-mewhat agree	So-mewhat disagree	Strongly disagree
Make a gradual announcement in several stages				
Give the patient hope				
Avoid giving too much information all at once				
Due to a lack of time				

4- Did you say:

	YES	NO
Possible treatments (surgery, radiotherapy, chemotherapy)		
The stage of the cancer		
The prognosis		
Possible supportive care		
Side effects of treatments		

5- Have you provided your patient with any materials (written documents, diagrams, online resources, etc.) explaining their condition?
Yes ☐ No ☐

6- Do you feel you have answered all your patient's questions?
Yes □ No □

7- Did you arrange another appointment with the patient at the end of this consultation?
Yes □ No □

PRE-NOTIFICATION: FEELINGS AND USEFULNESS

1- Did you feel challenged during this consultation in relation to:

	Yes	No
Diagnostic uncertainty		
A lack of prognostic information		
A lack of therapeutic information		
Due to relational/emotional difficulties		

2-Do you think this consultation was helpful for the patient?
Yes □ No □

3-What role do you think you played in the 'overall disclosure' of your patient's cancer?
-Very important □
-Quite important □
-Not very important □
-Not very important □

AREAS FOR IMPROVEMENT AND TOOLS TO BE DEVELOPED:

1-Do you think that a preliminary cancer diagnosis by the GP, prior to the specialist's diagnosis, should be systematically incorporated into the disclosure process?

I completely agree □
Somewhat agree □
Somewhat disagree □
Strongly disagree □

2-Would you like to have access to additional information resources on cancer?
Yes □ No □

If yes: Tick the relevant options

	About the disease	About treatment	On the pro-gnosis	On the supportive care available
For yourself				
To give to the patient				

3-What oncology information resources do you use?
-Cancer care network □
-Websites (HAS, Oncomip, etc.) □
-Guidelines/medical press □
-University hospital teaching □
-Colleagues □
- Continuing medical education / Peer group □

4-Are you familiar with the Oncomip website?
Yes □ No □

5-Would you be interested in further training on how to discuss the possibility of cancer with your patients?
Yes □ No □

APPENDIX 2 - APPROVAL BY THE ETHICS COMMITTEE OF THE DEPARTMENT OF GENERAL MEDICINE AT THE UNIVERSITY OF TOULOUSE

Département Universitaire Médecine Générale

Commission Ethique du Département de Médecine Générale de Midi Pyrénées

Secrétariat : *Dr Motoko DELAHAYE*
30 Avenue des Arcades, 12000 Le Monastère
Tél. : 05.65.42.58.69 – Tél. Port : 06.88.05.55.52– motoko.delahaye@dumg-toulouse.fr

Président : Mme Laurencine VIEU
Secrétaire : Mme Motoko DELAHAYE

AVIS A LA COMMISSION ÉTHIQUE DU DÉPARTEMENT UNIVERSITAIRE DE MÉDECINE GÉNÉRALE DE MIDI-PYRENEES

Renseignements concernant le demandeur :

Nom : BERGES Magali
Qualité : Médecin généraliste non thésée
Adresse : 15 rue Sainte Marthe 31000 TOULOUSE
Courriel : magaliberges@gmail.com
Numéro de téléphone : 06 87 11 54 24

Renseignements concernant le promoteur :

Nom : Faculté de médecine de Toulouse Rangueil, DUMG, sous la direction du Dr Marie-Eve ROUGE-BUGAT
Qualité : Docteur en médecine, Maitre de stage universitaire
Adresse :
Courriel : marieeve.rouge-bugat@dumg-toulouse.fr

Titre complet de la recherche :

Point de vue des médecins généralistes au sujet de la réalisation d'une pré annonce de cancer en amont de la consultation d'annonce.

AVIS DE LA COMMISSION (Réservé à la Commission)

AVIS FAVORABLE ***N° 2017-014*** ***LE 12/8/2017***

Dr Motoko Delahaye

APPENDIX 3 - CNIL DECLARATION OF COMPLIANCE USING REFERENCE METHOD NO. 3

CNIL.
3 Place de Fontenoy - 75334 PARIS Cedex 07
T. 01 53 73 22 22 - F. 01 53 73 22 00
www.cnil.fr

RÉCÉPISSÉ

Madame BERGES Magali
MÉDECIN GÉNÉRALISTE REMPLAÇANT
15 RUE SAINTE MARTHE
31000 TOULOUSE

DÉCLARATION DE CONFORMITÉ À UNE MÉTHODOLOGIE DE RÉFÉRENCE

Numéro de déclaration

2081263 v 0

du 06 juillet 2017

A LIRE IMPERATIVEMENT

La délivrance de ce récépissé atteste que vous avez transmis à la CNIL un dossier de déclaration formellement complet. Vous pouvez désormais mettre en oeuvre votre traitement de données à caractère personnel.

La CNIL peut à tout moment vérifier, par courrier, par la voie d'un contrôle sur place ou en ligne, que ce traitement respecte l'ensemble des dispositions de la loi du 6 janvier 1978 modifiée en 2004. Afin d'être conforme à la loi, vous êtes tenu de respecter tout au long de votre traitement les obligations prévues et notamment :

1) La définition et le respect de la finalité du traitement,
2) La pertinence des données traitées,
3) La conservation pendant une durée limitée des données,
4) La sécurité et la confidentialité des données,
5) Le respect des droits des intéressés : information sur leur droit d'accès, de rectification et d'opposition.

Pour plus de détails sur les obligations prévues par la loi « informatique et libertés », consultez le site internet de la CNIL : www.cnil.fr.

Organisme déclarant

Nom : GCS INST UNIVERSITAIRE CANCER ONCOPOLE

Service : IUCT ONCOPOLE

Adresse : 1 AVENUE IRENE JOLIOT-CURIE

Code postal : 31100
Ville : TOULOUSE

N° SIREN ou SIRET :
801812009 00018

Code NAF ou APE :
8610Z

Tél. : 08 92 97 70 56
Fax. :

Traitement déclaré

Finalité : MR3 - Recherches dans le domaine de la santé sans recueil du consentement

Transferts d'informations hors de l'Union européenne : Non

Fait à Paris, le 06 juillet 2017
Par délégation de la commission

Isabelle FALQUE PIERROTIN
Présidente

APPENDIX 4 - SOCIO-DEMOGRAPHIC CHARACTERISTICS OF GENERAL PRACTITIONERS

	Men (N=55)		Women (N=26)		Total (N=81)		
	M	(SD)	M	(SD)	M	(ET)	p
Age (years)	54.9	(10.2)	48	(9.3)	52.7	(10.4)	**<0.01**[W]
Installation duration (years)	23.8	(11.6)	15	(8.3)	21	(11.3)	**<0.01**[W]
	N	(%)	N	(%)	N	(%)	p
Location of practice:							
Rural	15	(27.3)	6	(23.0)	21	(25.9)	
Semi-rural	25	(45.4)	10	(38.5)	35	(43.2)	
Urban	15	(27.3)	10	(38.5)	25	(30.9)	0.59[C]
Type of practice:							
Solo	16	(29.1)	5	(19.2)	21	(25.9)	
Group + MSP	39	(70.9)	21	(80.8)	60	(74.1)	0.34[C]
Patient follow-up period:							
< 5 years	15	(27.3)	18	(69.2)	33	(40.7)	
> 5 years	40	(72.7)	8	(30.8)	48	(59.3)	**<0.01**[C]
Doctors with training[1] :							
Yes	4	(7.3)	1	(3.8)	5	(6.2)	1.00[F]

[1] DU/DIU/Capacity/DESC: Palliative care, pain management, oncology
M = mean; SD = standard deviation; N = sample size; % = percentage
[F] = Fisher's test; [C] = Chi-squared test; [W] = Wilcoxon-Mann-Whitney test; **<0.05 =** statistically significant result