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Personalized informational needs of cancer patients: A cross-sectional study in Greece

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Εξατομικευμένες ανάγκες πληροφόρησης ασθενών με καρκίνο -Μία συγχρονική μελέτη

Abstract at the end of the article

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Introduction: Cancer patients' overall health is affected by their health QoL and the social support that they receive. Also, they have multifarious needs included informational needs for social support and for their disease.
Purpose: To assess the informational needs of Greek cancer patients and the possible factors that may affect them.
Material-method: This was a cross-sectional quantitative study The sample compromised with 494 cancer patients. It was convenience and selected from the Chemotherapy Unit of the anticancer public hospital in a major city of Northern Greece. A special questionnaire was utilized for the goals of this study, and it was comprised of two parts.
Results: Most of them were women, married, from the Region of Central Macedonia, and mostly had either lung (22.1%, n=109) or breast cancer (27.1%, n=134). 57.5% of the participants reported having communication with Cancer Patient Guidance Center K3 by themselves, while 41.9% of the participants disclosed communication through the caretaker. Among cancer patients, communication with K3 differed significantly by initiator and mode (χ^2 (4) =33.8, p<0.001, Cramer's V=0.32). Gender correlated with communication initiator (r=0.280, p<0.001), while cancer type correlated with first request (r=0.280, p=0.021). Logistic regression showed marginal associations for caregiver-initiated contact (OR=0.60, p=0.054).
Conclusions: Telecommunication and tele-support are transforming cancer care, providing patients with options to address their informational and other needs. It is important for nurses and other care professionals to address the needs of their patients and help them with appropriate interventions

Key words: *informational needs, cancer, patients, personalized care, Greece.*

Introduction

Cancer remains one of the leading causes of morbidity and mortality worldwide, imposing a significant burden for patients, families, and healthcare systems. According to the World Health Organization, cancer accounted for nearly 10 million deaths globally in 2020[1], with breast, lung, colorectal, prostate, and stomach cancers being among the most frequently diagnosed types.[2] Despite advances in early detection, treatment, and survivorship care, the complexity of cancer as a chronic and life-threatening condition generates a wide spectrum of needs that extend beyond medical management.[3]

A growing body of research underscores the importance of informational support as a cornerstone of patient-centered cancer care. Information enables patients to participate actively in decision-making, reduces uncertainty, alleviates anxiety, and fosters adherence to treatment plans.[4] Conversely, inadequate or inconsistent information provision can exacerbate distress, diminish trust in healthcare providers, and impair health-related QoL.[5,6] Informational needs are not static; they evolve with the trajectory of the disease, from initial diagnosis and treatment through survivorship, recurrence, or end-of-life care.[7] Thus, healthcare systems must adopt flexible and personalized approaches that recognize patients as individuals with unique values, preferences, and coping mechanisms.

The concept of personalized informational needs derives from the broader paradigm of personalized medicine, which emphasizes tailoring care to individual characteristics rather than adopting a "one-size-fits-all" model.[8] In the context of cancer, personalization extends beyond molecular profiling and therapeutic strategies to encompass the provision of information and support. Patients differ in their desire for detail, preferred modes of communication, cultural expectations, and literacy levels.[9] Recognizing and respecting these preferences is vital for fostering patient autonomy and dignity.

In Greece, cancer represents a major public health burden. Socioeconomic disparities, regional inequalities, and limited availability of specialized oncology services compound the challenges faced by patients.[10] Despite advances in treatment, there is evidence that Greek cancer patients often report limited access to reliable information and insufficient guidance on navigating healthcare and social services.[11] For instance, only a small proportion of patients in previous studies felt adequately informed about their condition or available supportive care resources.[12] These findings suggest persistent gaps in communication and patient education that may undermine care effectiveness.

The role of nurses is central in addressing informational needs. Nurses often serve as the first point of contact, bridging the gap between patients and the healthcare system, interpreting medical information, and offering emotional reassurance.[13] In oncology, nurse navigators and specialized oncology nurses have demonstrated effectiveness in improving informational continuity, enhancing patient satisfaction, and reducing unmet supportive care needs.[14] Their proximity to patients during treatment phases positions them uniquely to identify evolving informational requirements and to tailor communication accordingly.

Recent research further emphasizes the link between informational support, psychosocial well-being, and quality of life. Patients who perceive that their informational needs are adequately met report lower levels of distress, depression, and uncertainty, as well as higher treatment adherence and overall satisfaction with care[15]. Conversely, unmet informational needs are associated with poorer coping outcomes, heightened anxiety, and reduced health-related QoL.[16] Importantly, informational needs intersect with demographic and clinical characteristics. Variables such as age, gender, education, and cancer type influence both the type and intensity of information sought.[17] For instance, women with breast cancer often report higher informational demands compared to men with prostate cancer, reflecting differences in disease visibility, treatment side effects, and sociocultural contexts. [18]

Within Greece, an important initiative addressing cancer patients' informational and supportive care needs is the Cancer Patient Guidance Center (K3, "Kapa3"), established in 2020. K3 provides holistic, patient-centered support by integrating medical, legal, financial, and psychosocial services within a single organizational framework. Through in-person, telephone-based, and digital services, K3 connects cancer patients and their caregivers with multidisciplinary professionals and trained volunteers, offering guidance throughout the disease trajectory.[19]

In Northern Greece, a Mobile Information and Management Unit was implemented in one of the largest oncological hospitals, in collaboration with the "Care in Adult Cancer Patients" Laboratory of the Department of Nursing at the International Hellenic University. This unit operates through a team consisting of a social worker, an oncology-specialized nurse, and trained volunteers,

Table 1. Demographic and clinical characteristics of the participants.

	n (% out of N)
Gender	
Male	296 (59.9)
Female	198 (40.1)
Marital status	
Married	369 (75.8)
Single	56 (11.5)
Divorced	23 (4.7)
Widows	39 (8.0)
Labor status	
Full time	74 (74)
Part time	25 (25)
Seasonal	1 (1)
Occupational status	
Employed	155 (32.3)
Unemployed	93 (19.4)
Retirees	223 (46.5)
Students	4 (0.8)
Other	5 (1.0)
Type of cancer	
Lung/ thorax	109 (22.1)
Breast	134 (27.1)
Colorectal/ colostomy/ colectomy	36 (7.3)
Small intestine	15 (3)
Mouth/ nasopharynx/ pharynx/ nose/ tongue/ larynx/ THS	37 (7.5)
Kidney/ prostate/ testicular/ bladder/ urothelial/ cystectomy	12 (2.4)
Skin/ BCC/ melanoma	13 (2.6)

aiming to inform patients, raise awareness regarding rights and available resources, and provide personalized guidance tailored to individual needs. The K3 digital platform functions as a flexible tool supporting patients as they navigate healthcare and social care services, with the overarching goal of improving quality of life and facilitating social integration during and after cancer treatment.[20]

Therefore, the present study aimed to assess the personalized informational needs of cancer patients in Greece by examining their interaction with the Cancer Patient Guidance Center (K3). Specifically, the study explored demographic and clinical characteristics, modes of communication, and types of informational requests, in order to provide evidence that may inform the development of targeted, patient-centered informational and supportive care interventions.

Materials and Methods

Design of the Study

A cross-sectional study was conducted in a large public Anticancer hospital in Thessaloniki, Northern Greece. Data collection took place between March 2022 and May 2023. The study followed a descriptive design, aiming to capture real-world information regarding cancer patients' informational needs and their

Table 2. Ways of communication with K3.

	n (%)
Person who communicated with K3	
Cancer patient	284 (57.5)
Caregiver	207 (41.9)
Family/ friend	3 (0.6)
Way of communication	
Hospital	65 (3.2)
Caretaker	1 (0.2)
Webpage	1 (0.2)
Newsletter	104 (21.1)
Telephone	318 (64.4)
Other	5 (1.0)

**CDC: Center for Disability Certification*

Table 3 Association between Person Initiating Contact and Mode of Communication with K3 (N=324)

Mode of communication	**Patient n (%)**	**Caregiver n (%)**	**p-value**
Telephone	71 (34.3%)	49 (41,9%)	<0.001*
Mobile Application (App)	53 (25.6%)	50 (42.7%)	
Hospital-based contact	54 (26.1%)	5 (4.3%)	
Informational leaflet	28 (13.5%)	13 (11.1%)	

Chi-square test of independence: $\chi^2(4)=33.8$, $p<0.001$.
Cramer's V=0.32, indicating a moderate effect size.

interaction with a structured guidance service.

Sample collection

The sample of this study was convenient and consisted of 494 eligible cancer patients. Eligibility criteria included: age ≥18 years, confirmed diagnosis of cancer, ability to read and communicate in Greek, and willingness to participate. Patients with a documented history of neurological or severe neuropsychiatric disorders were excluded.

One of the authors of this study approached the participants- patients in the chemotherapy unit of the hospital while they were waiting for their appointment with their doctor.

The aims of this study were fully explained to the possible participants, including the voluntarily nature of their potential participation, the anonymity, and confidentiality of their recorded data. Those who agreed to take part in the study provided a written informed consent. The study was approved by the Scientific Council of the Hospital (decision 20131/01.07.2022). The research was conducted in strict adherence to the ethical tenets outlined in the Declaration of Helsinki

Data collection instrument

A structured, study-specific questionnaire was developed for the purposes of this research. The instrument consisted of two sections. The first section collected demographic and clinical information, including gender, age, marital status, employment and occupational status, and type of cancer diagnosis. Cancer types were recorded in predefined categories reflecting the most common malignancies treated in the study setting. The second section focused on participants' interaction with the Cancer Patient Guidance Center (K3). Specifically, it included items regarding:

a) person who communicated with K3 (himself/ herself or his/ her caretaker or his/her friend),

Table 4: Correlation between demographic, clinical, and communication variables

Variables	Person who communicated with K3		First application to K3	
	r	p	r	p
Gender	0.289,	<0.001		
Cancer type		Ns	r=0.280	p=0.021
Labour status	–0.177	<0.001		
Age	–0.095	0.034	–0.190	<0.001
Way of Communication	–0.229	<0.001		Ns

Table 5: Binary Logistic regression predicting App (vs Telephone) communication

Predictor	OR	95% CI	p-value
Who communicated	0,60	0,36-1.01	0.054
Age	1,02	1.00-1.05	0.073
First application to K3	1,46	0.87-2.44	0.151
Gender	0,69	0.43–1.20	0.208
Labour status (full time vs seasonal)	1,02	0.34–1.39	0.295
Labour status (part time vs seasonal)	1.12	0.56–2.23	0.748

b) the way that communication was achieved (hospital or caretaker or webpage or newsletter or telephone or other) and

c) the type of request through a question that required a written answer.

A pilot study was not conducted, as the questionnaire was designed as a brief, descriptive data collection tool rather than a psychometric instrument. The items focused on clearly defined, factual information (e.g. mode of communication, type of informational request, involvement of patient or caregiver) and did not aim to measure latent constructs, attitudes, or psychological states.

Given the straightforward nature of the questions and their alignment with the study objectives, pilot testing was not considered necessary, as it was unlikely to yield additional information regarding reliability or item refinement. Similar methodological approaches have been described in descriptive studies employing simple and objective data collection instruments. Furthermore, the clarity, relevance, and appropriateness of the questionnaire items were reviewed by an expert panel prior to data collection, ensuring adequate content and face validity for the purposes of the present study. [21]

Statistical analysis

The statistical software package for social sciences IBM SPSS (IBM SPSS Statistics for Windows, version 25.0, Armonk, NY, USA; IBM Corp) was used for the analysis of the data of this study. Continuous variables were described using means and standard deviations (± standard deviations), and categorical variables were presented as frequency and percentage (%). Descriptive statistics were used for demographic characteristics.

Kolmogorov–Smirnov and Shapiro–Wilks tests were conducted and Q-Q plots were constructed to investigate normality in data. Skewness and kurtosis were also examined. Data distribution did not meet the criteria for normality in most of the variables, so non-parametric tests were used. Spearman coefficient was utilized to assess correlations amongst variables, and Mann–Whitney-U test and Kruskal–Wallis-H test was used for assessment of mean ranks between subgroups. Tests were two-tailed, and the level of statistical significance was set at $p \leq 0.05$. Chi-square test was used for comparisons of frequencies.

Results

In the research, participated 494 eligible cancer patients. The mean age of the sample was 60.19±13.03 years with a wide range from 20 to 94 years old. 59.9% (n n=296) of the participants were women , 61.3% (n=301) reported being residents of the Region of Central Macedonia, and also the majority (75.8%, n=369) stated that they were married. Nearly half of the participants (46.5%, n=223) identified as retirees. Percentage of 27.1% (n=134) reported having breast cancer and 22.1% (n=109) reported having lung cancer. Table 1 illustrates the demographic as well as the clinical characteristics of the participants.

All cancer patients reported to have contacted K3, either by themselves or through a third person, in order to convey their requests and to get informed about the issues that they were concerned about. 57.5% of the participants reported having communication with K3 by themselves, while 41.9% of the participants disclosed a communication through the caretaker. Also, the majority of the participants (60.5%) reported having a second request while only 3% disclosed having a third request. Table 2 describes the ways that the participants communicated with K3.

The first request that the patients made to K3 showed that the vast majority of them (75.3%) prioritized the creation of the Greek Center for Disability Certification (CDC; in Greek it is pronounced as "Κέντρο Πιστοποίησης Αναπηρίας"; ΚΕΠΑ), 23.3% reported to be interested about their exemptions and benefits, and 1.2% reported to request an appointment to the hospital.

A statistically significant association was observed between the person initiating contact with K3 and the mode of communication ($\chi^2(4)=33.8$, $p<0.001$). The effect size was moderate (Cramer's V=0.32), indicating a meaningful relationship between the two variables. Caregivers were significantly more likely to use the mobile application (42.7%) compared to patients themselves (25.6%), whereas patients more frequently preferred hospital-based communication (26.1% vs. 4.3%). Telephone communication was commonly used by both groups (34.3% of patients and 41.9% of caregivers). These findings suggest that communication preferences differ according to the role of the individual initiating contact, highlighting the importance of maintaining multi-channel and digitally supported access pathways in oncology supportive care services.

Several significant correlations were identified among demographic, clinical, and communication-related variables. Gender correlated with the person who communicated with K3 ($r = 0.280$, $p < 0.001$), while cancer type correlated with the first application to K3 ($r = 0.280$, $p = 0.021$). Negative correlations were found between labour status and the person who communicated with K3 ($r = –0.177$, $p<0.001$), age and first application to K3 ($r = –0.095$, $p=0.034$), age and the person who communicated with K3 ($r = –0.190$, $p<0.001$), and between the person who communicated with K3 and the way of communication ($r = –0.229$, $p<0.001$).

A binary logistic regression model was fitted to examine factors associated with using the mobile application (App) versus telephone communication. In the analytic sample, caregiver-initiated contact showed a marginally lower likelihood of App use compared with patient-initiated contact (OR=0.60, 95% CI 0.36–1.01, p=0.054). Increasing age was also marginally associated with higher odds of App use (OR=1.02 per year, 95% CI 1.00–1.05, p=0.073). Sex, labour status, and first application to K3 were not significantly associated with App use in this model (all $p>0.05$). Overall model fit was modest (McFadden $R^2=0.037$).

DISCUSSION

This study provides novel insights into the personalized informational needs of cancer patients in Greece by examining their interaction with a structured cancer guidance service. The findings demonstrate that informational needs extend well beyond clinical and treatment-related issues and are strongly oriented toward administrative, social, and supportive care concerns, particularly disability certification and access to social benefits. This pattern highlights the substantial bureaucratic and socioeconomic burden associated with cancer, which often coexists with clinical challenges and

significantly affects patients' quality of life and psychosocial well-being.

The predominance of requests related to disability certification is consistent with previous literature indicating that financial strain, administrative complexity, and lack of navigation support represent major sources of distress for cancer patients.[10, 22] International evidence suggests that unmet informational and financial needs are associated with increased anxiety, reduced coping capacity, and lower health-related quality of life.[5,15] The present findings reinforce the concept that informational needs in oncology are multidimensional and closely linked to broader social determinants of health rather than limited to biomedical information alone.

A statistically significant association was identified between the person initiating contact and the mode of communication (χ^2=33.8, p<0.001), with a moderate effect size (Cramer›s V=0.32). This suggests that communication preferences are influenced by relational roles rather than being random choices. Caregivers were more likely to use the mobile application, whereas patients themselves preferred hospital-based communication. This differentiation may reflect generational differences in digital literacy, functional limitations during treatment, or variations in perceived security and trust in communication channels.

The regression analysis indicated only marginal associations between caregiver involvement and App use, as well as between age and digital communication preference. Although not reaching conventional statistical significance, these trends suggest a gradual shift toward digital engagement in oncology care. The modest model fit (McFadden R^2=0.037) further highlights that communication preferences are likely influenced by additional psychosocial or contextual variables not captured in the present dataset, such as education level, digital literacy, disease stage, or caregiver burden.

Gender differences were also evident. Female patients were significantly more likely to initiate communication independently, whereas male patients more often relied on caregivers. These findings are consistent with previous research indicating that women tend to demonstrate higher levels of health information-seeking behavior and active engagement in care decisions.[9,17] Conversely, men may be more likely to delegate communication responsibilities within the family context. From a nursing perspective, these patterns underscore the importance of gender-sensitive approaches that support both patient autonomy and caregiver involvement.

The findings highlight the central role of oncology nurses in identifying and addressing both explicit and latent informational needs. Nurses serve as key mediators between patients and the healthcare system, translating complex medical and administrative information, providing emotional reassurance, and facilitating access to supportive resources.[4] Structured guidance services such as K3, particularly when linked to nursing-led initiatives and multidisciplinary teams, may strengthen continuity of care and reduce unmet supportive care needs.

Within this context, the Cancer Patient Guidance Center (K3) represents an integrated and patient-centered model of informational and supportive care. By combining professional expertise with structured volunteer involvement, K3 facilitates access to reliable information and assists patients in navigating complex healthcare and social care systems. Similar integrated guidance models have been shown to improve patient satisfaction, reduce unmet supportive care needs, and enhance continuity of care.[8,13] The present study suggests that such models may be particularly valuable in healthcare settings characterized by administrative fragmentation and socioeconomic inequalities.

The high utilization of telephone communication reflects the growing importance of tele-support in contemporary oncology practice. Since the COVID-19 pandemic, remote communication modalities have become integral to cancer care delivery[23,24]. However, the present findings suggest that tele-support should complement rather than replace in-person services, especially for patients who may feel more secure within institutional settings. Previous studies have demonstrated high levels of patient satisfaction with telephone- and web-based cancer support services, particularly in relation to informational continuity, emotional reassurance, and accessibility.[24,25]

Limitations

This study has certain limitations that should be considered when interpreting the findings. First, the study was conducted in a single public anticancer hospital in Northern Greece, which may limit the generalizability of the findings to other regions or healthcare settings. Nevertheless, the hospital serves a large and diverse patient population, offering valuable insight into real-world informational needs within the Greek healthcare context.

Second, although the study focused on patients' informational requests, certain clinical variables, such as cancer stage or treatment regimen, were not examined and may influence communication patterns and informational needs. In addition, psychological support emerged as a relatively infrequent explicit request; however, the small number of patients reporting such needs limited further subgroup analyses.

Despite these limitations, the study has notable strengths. To the authors' knowledge, this is one of the first studies in Greece to examine cancer patients' informational needs through a structured non-profit guidance organization, with a clear focus on nursing-relevant outcomes. The findings provide meaningful evidence for nursing practice and may inform the development of targeted, patient-centered informational and supportive care interventions.

Conclusions

This was cross-sectional study in Greece, was conducted in order to illustrate the informational needs of cancer patients as have seen by non-profit organization K3. The participants contacted K3 either themselves or through a caregiver, with the former to be mostly women and the latter mainly men, while most of the participants communicated with K3 by telephone. The majority of the participants' first requests to K3 were to obtain a CDC and inquire about their benefits and exemptions. More than half of them had a second request related to their informational needs for their benefits and exemptions, and only a few of them had a third request solely for psychological support. Telecommunication and tele-support are novel strategies particularly for those people, and literature has shown that individuals with cancer have various informational and other needs, particularly psychological. As every study has its limitations, it is required that future surveys consider the results and the barriers of this study and provide more information on this topic to the scientific community, to manage precisely the informational and other needs of these individuals.

ΠΕΡΙΛΗΨΗ

Εξατομικευμένες ανάγκες πληροφόρησης ασθενών με καρκίνο -Μία συγχρονική μελέτη

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Εισαγωγή: Η υγεία των ασθενών με καρκίνο επηρεάζεται από την ποιότητα ζωής τους, καθώς και από την κοινωνική υποστήριξη που λαμβάνουν Έχουν ποικίλες ανάγκες, μεταξύ των οποίων είναι και οι ανάγκες πληροφόρησης, καθώς και οι ανάγκες ενημέρωσης και κοινωνικής υποστήριξης για την ασθένειά τους.

Σκοπός: ο σκοπός της παρούσας μελέτης ήταν η διερεύνηση των αναγκών πληροφόρησης των Ελλήνων ασθενών με καρκίνο και των πιθανών παραγόντων που τις επηρεάζουν.

Υλικό-μέθοδος: Πρόκειται για μια συγχρονική ποσοτική μελέτη. Το δείγμα αποτελούνταν από 494 ασθενείς. Διενεργήθηκε δειγματοληψία ευκολίας σε Μονάδα Χημειοθεραπείας αντικαρκινικού δημόσιου νοσοκομείου σε μεγάλη πόλη της Βόρειας Ελλάδας. Για τους σκοπούς της παρούσας έρευνας χρησιμοποιήθηκε ειδικό ερωτηματολόγιο, το οποίο αποτελούνταν από δύο μέρη.

Αποτελέσματα: Το μεγαλύτερο ποσοστό του δείγματος ήταν γυναίκες, παντρεμένες, που προέρχονται από την Περιφέρεια της Κεντρικής Μακεδονίας και είχαν κυρίως καρκίνο πνεύμονα (22,1%, n=109) ή καρκίνο μαστού (27,1%, n=134). Βρέθηκε στατιστικά σημαντική συσχέτιση μεταξύ του ατόμου που ανέλαβε την επικοινωνία με το K3 και του τρόπου επικοινωνίας ($\chi^2(4)=33,8$, $p<0,001$, Cramer's V=0,32). Το φύλο συσχετίστηκε με το πρόσωπο που επικοινώνησε με το K3 ($r=0,280$, $p<0,001$), ενώ ο τύπος καρκίνου συσχετίστηκε με το πρώτο αίτημα ($r=0,280$,

p=0,021). Η δυαδική λογιστική παλινδρόμηση ανέδειξε οριακά στατιστικά σημαντική συσχετίση για την επικοινωνία μέσω φροντιστή (OR=0,60, p=0,054)

Συμπεράσματα: Οι τηλεπικοινωνίες και η τηλε-υποστήριξη μεταβάλουν τη φροντίδα των ασθενών με καρκίνο, παρέχοντάς τους επιλογές για την αντιμετώπιση των αναγκών ενημέρωσης, αλλά και άλλων αναγκών. Οι νοσηλευτές και οι άλλοι επαγγελματίες υγείας είναι σημαντικό να γνωρίζουν τις ανάγκες των ασθενών και να σχεδιάζουν κατάλληλες παρεμβάσεις.

Λέξεις-κλειδιά: ανάγκες πληροφόρησης, καρκίνος, ασθενείς, εξατομικευμένη φροντίδα, Ελλάδα

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