



## The challenge of truth telling across cultures: a case study

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### Abstract

Accompanied with various opinions across cultures, truth telling is a major debate in bioethics. Many studies have focused on attitudes toward truth disclosure. We intend to review several relevant research studies, and discuss the issue through a clinical case consultation.

It seems that while "the right to know" is emphasized in bioethics, in some cultural contexts, health professionals fear communicating bad news. The patients may not receive information directly, because it is believed that the truth may make the patient feel hopeless and unable to cope with the problem. Nevertheless, some believe that sharing information may strengthen a trusting relationship between patients and medical professionals.

Extensive efforts are in process in some societies to make patient rights to know the truth as a natural part of medical practice. However, in some cases, the principles of respect for patient autonomy require us to accept patient's refusal to know the truth, with the provision that he assigns someone to receive information and make medical decisions on his behalf. In conclusion, it is suggested that healthcare professionals should not act on a unique presumption in all cases and they should explore what the real interest of patient is, in order to respect individual autonomy.

**Keywords:** *Truth telling, Ethics consultation, Autonomy, Informed consent, Culture, Clinical ethics*

### INTRODUCTION

Physician-patient communication has changed significantly in recent decades in most countries throughout the world. Before the era of contemporary bioethics, the key decision makers in medical practice were physicians. They visited patients, prescribed drugs and their main duty was to save life and avoid death. Information about the disease and the treatment was often not shared with

patients, and they were rarely included in the decision making as to how the treatment should proceed. Sometimes physicians even concealed the diagnosis from patients. Some people even died without knowing what their disease was.

However, there has been a rapid change from a paternalistic approach to an individualistic one. Telling the patient the truth is now a common

practice in many western countries and is also more acceptable than in the last decades in the eastern cultures. Different interpretations of respect for autonomy and a greater emphasis on the role of the family and the community in patient care have resulted in a different approach in caring for patients in the East.

Patient's capacity is a main element of autonomy-based decision making which may be influenced by different internal (e.g. mental capacity, stress, and level of understanding of medical information) and external (e.g. culture, and socio-economic class) factors (1). Interpersonal relationships have also a significant effect on the sense of autonomy in various cultural contexts. Although family request of "do not tell" the truth and their strong resistance to informing patients about their diseases may confuse healthcare professionals in some societies (2), it may also reflect divergence in patients' interests in people.

Many research studies in recent years have focused on the attitude and practice of health care teams about whether and how to disclose diagnoses to patients with cancer or terminal illness. This has been the subject of many researches in recent years. In this paper, we intend to review the relevant studies and address the following questions:

1. Is truth-telling acceptable in different cultures?
2. Is there objective evidence that patients, regardless of their country, want to know the truth about their diseases?
3. What is the moral force of the family or the physician claiming that telling the truth is harmful to the patient?
4. Are there justifiable cases in which the physician is permitted not to tell the truth?

The aim of this paper is to clarify these questions through a comprehensive assessment of one clinical case.

### **THE CASE**

Mrs. B, 34 years old, comes to the emergency department for dressing a small ulcer on her forehead. Previously in a good health, she has fallen on the ground after a sense of lightheadedness. It seems to you, as a physician, that the patient is pale. So you ask her to do some laboratory studies including CBC for evaluation of anemia. She agrees and does the work-ups. When you receive the results, you realize that the patient has leukemia. In each of the following situations, what is your ethical duty?

1. The patient herself does not come back to receive the lab results. Instead, her husband comes to you to consult about the results. Should the physician disclose this information to the husband?
2. In fact the information is disclosed to him and he asks you not to tell his wife the truth and to tell

her only that she has anemia and needs hospitalization and treatment. He explains that informing her might cause her to lose hope.

3. In the course of events, Mrs. B sees the results and asks you not to tell the diagnosis anyone, including her family. She thinks this news may put a strain on the family members and make them worried. They are going to go to a 10-day trip together and she promises you that she will begin her treatment as soon as they come back home.

### **TELLING THE TRUTH**

Physician paternalism is no longer acceptable to many people because of the dramatic shift toward individual autonomy in the recent decades. Informed about their diseases and therapeutic approaches, many patients prefer to participate actively in the decision making process. The role of family and friends as spokespersons is reduced considerably in autonomy-centered systems if the patient has capacity to speak for herself. However, the attitudes of patients and doctors towards the disclosure of information can still vary from culture to culture. In some countries, family members make decisions for patients, and they sometimes fail to follow the patients' interests and priorities. Since such patients are psychosocially dependent on the family, they permit their family members to decide on their behalf and seldom defy their decisions. Table 1 summarizes data from some research studies in different countries (3-9).

In western countries, overall approximately 80–90% of patients are given the truth about their diagnosis, whereas in other cultures, figures can range from 0 to 50% (10). Two surveys conducted in the USA shows that clinicians' practices have changed significantly over recent decades. In one study conducted in 1961, 88% of physicians did not routinely discuss a diagnosis of cancer with their patients, whereas almost 20 years later in 1979, 98% of those surveyed generally did discuss the diagnosis (10-12). However, as Hanssen says '*disclosure of diagnosis and prognosis, and discussions of for instance termination of treatment reflect mainstream liberal Western cultural values, and are not even necessarily supported everywhere in Europe.* (13)'. Hanssen discusses examples from Italy, Japan, Asian Arabs, and Hispanics. Italy is one European country where '*the opportunity not to reveal to the patient or to mitigate a serious or lethal prognosis*' is evaluated by physicians (13, 14). In spite of persistent cultural resistance, truth-telling attitudes have evolved in Italy in recent decades too (15).

In contrast to Western individualistic cultures, most traditional Eastern cultures place more emphasis on the collective role of family in decision-making. In China, for instance, the long-standing influence of Confucian philosophy has

established “harmony” as an essential and important social value, as Lai states (16). Individual and family harmony is believed to be essential for both the prosperity of a family and a nation. The essential role of these values in Chinese society is captured in a well-known Chinese proverb: 'Family harmony makes everything successful and prosperous' (16). Lai also emphasizes that 'truth telling in Taiwan may also be influenced by four major

*social-cultural and ethical factors: family as a key player in medical[ly]-related decision making, harmony as an essential value for both the individual and family, taboo about discussing death and related issues, and ethical concerns in truth telling: the predominant value of non-maleficence (do no harm) leads to not telling the truth'*. In the following we may find a definition of harm which may be accompanied with telling the truth.

**Table 1-** Some research studies about truth telling in different countries.

References	Research Sample	Results
Mosconi et al. 1991 (3)	1171 Italian breast cancer patients and their physicians	- Only 47% of the patients reported having been told that they had cancer. - 25% of their physicians stated they had not given accurate information.
Blackhall et al. 1995 (4)	800 people with different ethnicity, Los Angeles County, California	- Korean Americans (47%), Mexican Americans (65%), European Americans (87%), and African Americans (88%) believed that a patient should be told the diagnosis of metastatic cancer. - Korean Americans (35%), Mexican Americans (48%), African Americans (63%), and European Americans (69%) believed that a patient should be told of a terminal prognosis.
Ruhnke et al. 2000 (5)	400 Japanese physicians, 65 patients; and 120 US physicians, 60 patients	- Few Japanese physicians (17%), but 42% of patients agreed that a doctor should inform the patient of a cancer diagnosis. But at least 80% of US physicians and patients agreed. - 80% of Japanese physicians and 65% patients agreed that a doctor should inform the patient's family of the diagnosis. A minority of US physicians (6%) and patients (22%) agreed.
Mayer et al. 2005 (6)	362 Japanese and 350 US Pediatric oncologists	- Japanese physicians (61.8%) did not explicitly tell the child the diagnosis; only 9.5% always told. - 65% of the US physicians always explicitly told the child the diagnosis.
Tavoli et al. 2007 (7)	142 Iranian patients, Tehran, Iran	- Only 48% of hospitalized patients with gastrointestinal cancers were aware that they had cancer and the rest did not know their diagnosis. (The researchers asked patients and their families in the separate sessions about the disease and the reason of hospitalization.)
Erer et al. 2008 (8)	104 cancer patients, Medical Oncology Department of Uludag University, Turkey	- 86.5% positive response to the items that the patients have the right to be informed, - 92.3% agreed that the physician should inform the patient on the diagnosis and the treatment, - 76.9% believed that the physician is obliged to inform the patient
Kazemi et al. 2010 (9)	200 Iranian clinical practitioners, Tabriz University of Medical Sciences, Iran	- Twenty percent of physicians believed that a patient should be told the diagnosis of a serious terminal disease. But 8% stated that they won't tell the patient the truth. Most respondents (72%) believed that the decision may be different in different conditions and various socio-cultural contexts.

As a central point, death is a taboo subject in some traditional societies. Chinese believe that discussing or thinking about death or death-related concepts or approaching a dead body will hasten death. For example, hospitals rarely have a floor numbered '4' since the pronunciation of '4' in both Mandarin and Taiwanese is similar to that of 'death' (16). A nationwide survey of 229 palliative care workers (72.5% nurses and 16.6% physicians) in

Taiwan suggested that several factors made family members reluctant to tell patients the truth; first, the family did not know how to tell the truth, second, the family did not think it was necessary to tell the truth to elderly patients, and three, patients would be better or happier if they didn't know the truth (16). However, the question remains that whether the truth about the diagnosis should be concealed from a patient or not. Die Trill and

Kovalcik argue that it is difficult to prevent a patient (a child) from being informed about her/his illness (17). They say that: *'His interactions with other patients in the hospital, his increased exposure to the media, where cancer is frequently discussed, and the responses of those around him to his disease will increase his awareness of the seriousness of his condition'*. It means that many patients will know their diagnosis without direct disclosure by the physician or their family.

A comparison between Japanese and American Physicians' and Patients' attitudes towards telling the diagnosis of cancer to a child (6) is demonstrated in table 1. In Japan, historically it was not common to tell patients their diagnosis of cancer as it was traditionally believed that knowledge of cancer would dash hope (6,18). This probably was related with the lack of treatment options and inevitable death in the past decades, which is not true anymore. Most Japanese believed that a doctor should inform the patient's family of the diagnosis (not the patient) at first and should let them decide whether the patient should be told or not (5).

Ornek Buken states that in the physician-patient relationships in Turkey, the one who is primarily responsible for making decisions about the patient's treatment is not the patient but the patient's next of kin, and sometimes the diagnosis is known by everyone except the patient (19). Data from a limited research study done on 58 physicians and 150 medical students at Ankara University Medical Faculty Ibn Sina (Avicenna) Hospital showed that 52% of the physicians and medical students had a "protector, guardian" approach to the cancer patients (19).

In Iran, Kazemiyani has carried out in-depth interviews with 20 specialists about terminal diseases (20). All of the physicians said that considering cultural issues and negative psychological effects, they would tell the diagnosis to the family members first. Although they believed the patient has a right to know the truth, the specialists preferred not to tell the diagnosis directly before consultation with the family members (20). This is a situation where culture strongly influences medical decisions. Table 1 also shows the results of another study (7) in Iran. Also, in an investigation on 71 health professionals (physicians and nurses), most respondents (54%) said that they told the true diagnosis to less than 20% of their patients. When respondents were asked about the barriers or reasons, they mentioned families' request (18%) and time limitations (16%) as the reasons. Seven percent said that they do not inform patients because of the patients' own reluctance to know (21). It is also plausible if we conclude that this could be as a result of a lack of confidence of the physicians in terms of talking about such issues. Physicians in different cultural contexts may face this problem, and this could indicate their lack of

skills in communicating bad news in a health care settings.

As mentioned before, according to the major studies in the US regarding the disclosure of terminal illness to cancer patients, there was a dramatic change from 1960 to 1979, from not disclosing the truth, to full disclosure. By the late 1970s only 2% of surveyed US physicians did not reveal the cancer diagnosis to their patients (22). Nevertheless, the United States is becoming a multicultural society and physicians may encounter patients who have divergent ideas on this notion. For example, as Glass and Cluxton have written, in traditional Latino families, it is considered the husband's duty to hear the bad news and then to tell his wife what he thinks she would want to know (23). If the spouse is deceased, the adult children assume this role to honor their mother and to protect her from the unpleasantness of the bad news. And, because the patient may not be fully informed of the illness, the spouse or the children are expected to make decisions about the care that the patient would want to receive (23).

There is still a main question here of *'Do patients really want to know the truth?'* Patients' attitudes toward disclosure can vary from one cultural context to another. In the US, several studies indicate that people do want to know the truth about their illness and prognosis, even when the news is not good (23). Surveys in western populations have found that 83–99% of those surveyed would like to be informed of their diagnosis, with a somewhat lower figure in nonwestern countries of 24–74% (10). Many predictors of the desire for information have been identified, including age, level of education, ethnicity, a religious locus of control and in some studies, gender (10). A survey conducted by the US President's Commission in 1982 indicated that 94% of patients wanted to know everything about their condition, 96% wanted to be informed of a diagnosis of cancer and 85% wanted to be given a realistic estimate of their time to live, even if this were less than 1 year (11). However, in one study a greater percentage of Korean-born patients preferred to be given less information than did US-born patients (4,11).

In Taiwan, researchers in one study in 1982 found that more half (58.6%) of family caregivers opposed telling patients the truth, and only 39.7% agreed to tell the truth (16). The author states that *'major reasons for not telling the truth about cancer consisted of: worry that patients could not take the emotional impact, concern about not being able to manage the patients' emotional reaction after learning the truth, and protecting patients from harm'* (16). However, there have been changes in truth telling in cancer diagnosis over the past 20 years. A self-report survey of 195 people admitted to a medical center in southern Taiwan for a 3-day

health examination showed that 92.3% of participants preferred being informed of the truth about their cancer diagnosis and 7.7% did not (16,24).

### CASE CONSULTATION

The issues raised so far in the research studies can now be analyzed in regards with the presented case. Some practical approaches for ethical decision making on case consultation process will be used (25,26).

Mrs. B's physician accidentally makes a diagnosis of leukemia in this relatively young patient. The ethical question is whether the physician has the right to reveal the diagnosis to her husband or anybody else before informing the patient. What is his ethical duty, as a physician, when the patient or her husband asks him to conceal the diagnosis?

#### Systematic Description of the Case

1. **Medical indications:** Considering the primary diagnosis, some complementary Paraclinical evaluations are necessary. More specific blood examinations, bone marrow biopsy, and sometimes lumbar puncture are needed. Whether it affects granulocytes, lymphocytes, or monocytes determines the type of leukemia and its prognosis. The physician's decision may be different based on the type of leukemia and the fact that it is acute or chronic, but his duty is the same: seeking the welfare and interest of the patient.

The treatment then should be started promptly. The patient should be referred to an oncologist for scoring and staging of the disease. Under supervision of an oncologist, a combination of chemotherapy and other approaches such as drug therapy and radiotherapy may be administered. The physician should also consider cell therapy. So, the patient and her family need to be prepared for complicated therapeutic approaches fairly quickly.

2. **Patient preferences:** She is a legally competent woman, and she has the capacity to make decisions about the medical process. Moreover, she has the right to clearly state if she wants her husband or other family members to be informed about her disease, but she is reluctant to let her family know about her disease.

3. **Quality of life:** Although she has had a good quality of life so far, her life will be complicated with physical and psychological problems as the result of the severe and painful side effects of therapeutic approaches. In addition, receiving a cancer diagnosis may be seen as a death sentence by her and perhaps by her family. Unfortunately, without treatments, her life will be in danger, and delay will make a bad outcome more likely. The prognosis for various forms of leukemia varies widely. The 5-year survival may be less than 50% to more than 80% in different types of leukemia. In most cases the patient would have the best chance

for survival if the leukemia is diagnosed and cured in early stages.

4. **Contextual features:** Her cultural context is an important issue. Bad news such as a cancer diagnosis may be considered as a critical condition for her and the family. As mentioned before, in some cultures, the family members prefer to conceal the diagnosis to preserve the patient's hope and protect her from further distress. All previous discussions about characteristics of different cultures may be applicable in this case. In some cases difference in the attitudes might be important and should be considered and discussed by the health care team and the patient. For instance, the approaches would be completely different in a Chinese couple and an American one. We may also consider a situation in which one spouse has an Eastern culture and the other spouse is an American. Expectations and interests are different, and conflicts may arise. Physicians can play a distinguished role which may seem beyond their general duty. The physician should take into account this point that some decisions may be medically appropriate but not ethically sound. Sometimes there are psychosocial adverse effects which limit the options.

Besides, other issues such as treatment cost, outcome, her personal values and goals influence on the decision.

#### Assessment

It seems that she has good familial relationships and their trip is so important for her since she may think this will be the last opportunity for her to enjoy life. But, the patient is in a critical situation and she should receive medical treatment as soon as possible. The physician is faced with the conflict between how to respect her autonomy, preserving family unity and providing appropriate medical care for her serious condition.

#### Discussion

Any plausible solution in this case will need ethical justification based on well-established ethical principles and values. How to best respect for patient autonomy while acting in manner consistent with beneficence in medical practice, and their various interpretations under the influence of cultural variables, are the main issues to be discussed. Patient autonomy could be a key notion in this argument. In western bioethics, the sick person has a right to self-governance (21), so she has a definite right to know the diagnosis. Also, her information cannot be revealed to other people without prior consent, and she is the key decision maker about sharing information with the family or anybody else. However, as Surbone says, autonomy is a complex concept, which refers both to the

one's capacity to choose and the ability to implement one's choices (21). Autonomy is a necessary attribute of rational human beings and it is universally valid. However, both internal and external factors and resources contribute to one's autonomy and from the beginning to the end of our lives, we are embedded in a context of social relations, which shape us and sustain us. Thus, autonomy is always relational and situated, rather than simply a matter of individual choice (21).

Understanding "relational autonomy" helps framing the ethics of truth telling and understanding those many unsolved aspects of truth telling that go beyond cultural differences (21). Surbone adds to this interesting notion by suggesting that imposing the truth on an unprepared patient whose cultural expectation is to be shielded from painful medical truths is not necessarily an act of respect for autonomy. The notions of cultural sensitivity and of cultural competence are also essential to the discourse on truth telling (21).

In some cases, the patient may not wish to receive information directly, and select someone as a surrogate decision maker. Usually this means just to accept the family as the decision makers. In honoring a capable patient's wish not to be told healthcare information, the team respects the patient's autonomy to determine what he or she wants to know. This approach is not only culturally sensitive; it is also legally sound as long as the patient's wishes and chosen surrogate(s) are documented in the medical record (23). No doubt, quality of patient-physician communication is a pivotal point which helps physician to realize that s/he should communicate the information and the care plan with the family.

Benevolence and non-malevolence are also closely linked to the notion of truth telling. Some people may believe that the sick should be protected from harm by withholding the truth. As a case in point, as Lai states, for many Chinese, not telling a patient his/her cancer diagnosis is a way for the family to protect the patient from further hurt by the diagnosis and to preserve both individual and family harmony (16). Also, the predominant values of non-malevolence and family harmony in Taiwanese society determined truth-telling approach in cancer care (16). Physicians in the past have voiced concerns that revealing a cancer diagnosis would result in the loss of hope. Families are still often fearful that knowledge of cancer will result in despair, depression or result in increased suffering. Few studies have directly examined this question but it is likely that any increase in anxiety is transient. There is some evidence to support the notion that informing patients truthfully about a life-threatening disease does not result in a greater incidence of anxiety, despair, sadness, depression, insomnia or fear (10,27). It should be mentioned that ever-increasing knowledge and technological

advancements have increased hope for all patients including cancer patients. So cancer diagnosis is no longer as scary as it was in the past decades.

One study design based on the Utrecht School of Phenomenology in 9 cancer patients showed eight core themes describing the participants' lived experience: living with fears and uncertainty, loss of happiness, feeling of added responsibility, living in a state of emergency, sharing the pain, living the dilemma of truth telling, being disturbed by being pitied, and reliance on God (28). Furthermore, one study on 142 Iranian patients which has compared the quality of life between patients who were aware of cancer diagnosis and patients who were not, indicated that those who knew their diagnosis had a significantly lower degree of physical ( $P=0.001$ ), emotional ( $P=0.01$ ) and social functioning ( $P<0.001$ ), but the global quality of life and other functional scales including role functioning and cognitive functioning did not show any significant differences (7). There were no statistically significant differences in symptoms scores between two groups, except for fatigue which scored more frequently in patients who knew their diagnosis. The financial difficulties were also significantly higher in patients who knew their cancer diagnosis (7).

Conversely, many believe that informed patients have better communication with relatives and with their treating staff as well as greater trust in the care provided (10), and not telling the truth can harm patients in many ways (11). Many negative ramifications can result from not telling the truth to patients and families; for instance, it is predictably difficult to make treatment decisions that are consistent with personal goals in the absence of accurate and complete information. This may result in adverse physical and emotional suffering, as well as increased family expenses (23). Patients who remain uninformed about their condition may fail to seek medical attention when they should. They may also make decisions affecting their lives that they would not make if they were aware of their condition (11). Additionally, not telling patients the truth about their condition may entail deceiving them (11). Many patients feel frustrated because they sense they are not being included in their treatment plan. This frustration is especially true when family members are given more information than the patient without the patient's consent. Finally, when bad news is withheld from patients, they are denied the opportunity to get their affairs in order and may miss the opportunity to live meaningfully before their death (23). Lack of candor or outright deception, even when well intentioned, can undermine the public's confidence in the medical profession (11).

In addition, the benefits accompanying patients' adapting to their illness are frequently spiritual and emotional. For example, many people focus on

preparing themselves and their loved ones for the imminent death. For those with religious beliefs and spiritual sensitivities, making peace with God, others, and oneself is essential for achieving a sense of closure and integration (23).

However, there can be a socio-cultural difference in the prioritizing and weighting of the principles. For example, as Ornek Buken states, the principles of "do no harm and beneficence" sometimes take priority for Turkish patients over the principles of "respect for autonomy and justice" because of the structure of society, their customs and traditions and their sociocultural structure (19). The goal of the good physician, particularly in a cosmopolitan society, is to discern what the patient's preferences are and how s/he feels about the relationship between the triangle of patient, physician and the family. The third angle may not be acceptable in making decision in some societies, but it may be as important as other angles in some other cultures.

The physicians' communication skills and the manner with which he or she gives bad news is an important issue. As Glass and Cluxton point out (23), most healthcare professionals would not intentionally do anything to harm a patient or family. However, if healthcare professionals fail to become skilled in giving bad news honestly and sensitively, they may severely impede patients' and families' ability to deal with serious illness and/or prepare for death.

If we accept that the physician should tell the patient the truth, there are still some decisions to be made including determining to whom and to what extent the truth should be shared, and how the truth should be told. Some elements would be important in dealing with this issue including: the person who discloses the information, the manner of telling news, available supports (such as family, spiritual and social support), and the methods of coping with difficulties and stress in different cultures (29). Gold believes that the doctor alone should not make the decision about how much to tell an individual patient, even if s/he is well informed about the likely cultural preferences of the person seeking care (11). The needs of each person must be evaluated individually because illness is, in the first instance, a subjective experience, influenced by cultural, personal and religious beliefs and traditions (11).

The doctors do not have any right to lie to the patient but they are not obliged to tell the whole truth (30). Gold states *'too much information can be overwhelming and most physicians will recall instances of patients abandoning a successful treatment after hearing of a rare potential adverse effect'* (10). A sincere dialogue is required. Cultural differences between patients and health care professionals are potentially inevitable. Involvement of families in information and decision

making processes is also a concern, even within western societies where individualism is prized.

Putting these points together, it is obvious that physician cannot act based on a fixed default in all patients and s/he should take cultural context into account to decide how to communicate the information to the patient, her husband, and her family. As a default in Western culture, Mrs. B has the right to be informed about the diagnosis of her disease unless she is incompatible and someone else is her spokesperson and decision maker. The physician is not permitted to share the information with other people without her permission, including her family members. She is a competent woman and is capable of deciding whether to share the information. However, in an Eastern culture, family members have a caring role and they may be informed in order to help patient to cope with the problems of the diseases. She is going to travel with her family for 10 days, but the complementary work-ups and treatments should be started immediately. Family members in cancer patients may play a very important supportive role. It seems that for an effective and timely treatment, it is necessary that her close family members know about her disease, but if she is clearly reluctant the physician is ethically obliged to hide the patient's secrets. It is the physician's duty to clearly explain the harms and benefits of different decisions, but Mrs. B will make the final decision by her own.

Anyway, the physician should be respectful for all patients; those who insist on an absolute autonomy or those who refuse to know.

## Recommendations

Mrs. B's desires and preferences should be respected and her confidentiality should be protected as far as possible. Without treatments, her life would be in danger; but if she wants to take this potentially last trip with her family, the physician should not oblige her to stay and follow his recommendations.

No doubt, it is better that the physician not to be neutral. He/she should evaluate the situation; consider the different aspects of the disease and what will happen in coming weeks and months. Benefiting from psychosocial supports of family in patients struggling with the malignant disease may be of a key importance in many cases. The physician should evaluate the personality and psychological status of the patient and use appropriate language and skills to alleviate fear and possible hopelessness of the patient. Speaking about the new generations of anti-cancer drugs with high efficacy would be useful.

Physician should also emphasize to her the importance of beginning the therapeutic process as soon as possible. In the case when the patient's husband requests information about her wife's

disease, the principle of confidentiality and privacy require the physician not to tell him the information except when there is a presumed consent for disclosure as a cultural ruling. For making the best decision, there should be a discussion with the patient, the physician and health care team, and the close family. Prior to any decision, the physician and the ethics consultant if he or she is involved, should get familiar with the patient's goals, values, religious and cultural beliefs. A clear and sincere conversation is necessary. It should be clarified whether the patient wants to be the key decision maker, and/or to what extent she wishes the family to play a role.

## CONCLUSION

Physicians and nurses in some cultures fear communicating bad news because they may make the patient feel hopeless and unable to cope with the problem. Words like '*cancer*' may create a sense of death and despair in patients. Sometimes a diagnosis of a malignant disease results in the deterioration of patient's quality of life.

Advocates of truth telling believe that sharing information strengthens a trusting relationship between patients and medical professionals and also permits patients to make informed decisions. Many patients will know their diagnosis without direct disclosure by the physician or their family, so not telling the truth may ruin the trust between patient and physician. In addition, without disclosure of diagnosis and proper information about disease, the patient's choices would not be autonomous.

Patients may also deny their diseases or be reluctant to receive full information. The patients' own reluctance to know should also be respected. It is obvious that many internal and external factors may have an influence on individual capacity and self-determination. However, it seems that interpersonal relationships have a significant effect on the sense of autonomy in various cultural contexts. Excessive advocacy of autonomy is mostly based on the accepted interpersonal relationships in some Western societies; while different familial connect-

edness may give various meanings to autonomy; bearing in mind the social nature of human being. Finding a balance between appropriate medical decision and patient's preference is the physician's duty.

In other words, deontological approach which considers truth-telling a moral duty in all situations is not in accordance with respect for autonomy in Principlism. In a paternalistic interpretation of principles of autonomy and beneficence, all people from all various cultures may be treated equally. However, as an obligation, medical professionals ought to consider the variations in different cultural contexts and interpret these principles in any clinical cases according to their patients' cultural backgrounds. The right approach should be discussed through interactive consultation sessions among healthcare professionals, patients and the relatives.

In conclusion, a new perspective on the principle of autonomy is needed. It is so clear that respect for autonomy means that different people should be treated differently according to their ideas and beliefs. So, physicians should certainly have and use excellent skills in the areas of cultural sensitivity, and the decisions should be shaped by the patients' values and preferences. They should work to develop better skills in handling these difficult conversations, and consider various cultural differences as a key part of the essential skill set.

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