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Research Article

Challenges of Truth-telling to Patients and Their Families: A Qualitative Study

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Abstract

Background: The issue of truth-telling by healthcare providers is critically important, and it has legal and ethical implications.
Objectives: This study was conducted to investigate the perceptions and preferences of patients, families, and healthcare providers related to truth disclosure to identify barriers to this important aspect of communication.
Methods: A total of 27 participants (4 patients, 7 family members, 4 physicians, and 12 nurses) were recruited by purposeful sampling. Data were collected through in-depth, semi-structured interviews and analyzed by qualitative thematic analysis.
Results: Three main themes and eight sub-themes emerged from the data: (1) truth shock: Patient inability to face the truth, family inability to handle the truth; (2) secrecy during treatment and recovery: Withholding critical information from patients and families; family confusion about the patient's condition; families preventing truth disclosure to the patient; family fear of the truth's impact on the patient; and (3) patient's right to information: Lack of patient awareness of their rights; the importance of informing patients about their condition.
Conclusions: The findings of this study suggest that healthcare providers can deliver bad news to patients and their families more effectively and satisfyingly using an approach based on culture, patient preferences, and ethical values

Keywords: Truth Disclosure, Thematic Analysis, Delivering bad News, Health Care Providers

1. Background

Most healthcare providers face the need to disclose potentially distressing information to patients during their professional life. In terms of professional ethics, truth-telling means giving the patient and their family the necessary information to make them aware of the patient's condition and allow them to make informed decisions about medical care (1). From a social point of view, telling the truth about a disease means providing accurate and complete information. Even if the patient is not lied to, the facts may be skillfully hidden from them or ambiguous language used to give a false impression (2).

Historically, there is ample evidence in Greek medicine that health care providers failed to inform or misinformed their patients to force them to accept treatment (3). Not so long ago, most medical professionals believed that if the patient knew less about their condition, they would have a better chance of recovery. Accordingly, many of them hid information about impending death from their patients (4). Studies from the 1950s and 1960s showed that the majority of healthcare providers did not disclose cancer diagnoses to their patients. However, there has been a significant shift in this practice over the last two decades. In a study conducted in 2011, 97% of healthcare providers stated that they would disclose such a diagnosis (5). This change reflects evolving professional ethics that increasingly recognize the patient's right to accurate information. As a result, the patriarchal approach has given way to patient-centered behavior, which aims to improve patient satisfaction and minimize harm (3, 6).

Although disclosing disease diagnoses has become quite common in many countries, the current state of truth-telling in the health systems of Islamic countries is less clear (7, 8). As different cultures have different attitudes towards honesty and breaking bad news, patient autonomy and direct communication with the patient are prioritized in Western societies, while it is still preferred to convey bad news to the family in Eastern societies (9). Clause 6 of the Charter of Patients' Rights of the European Union (1994) (10), and the Declaration of the Rights of Patients of the American Hospital Association (11) emphasize the patient's right to receive comprehensive information on diagnosis, treatment, and prognosis. However, in some areas, there are still measures to hide the truth. Iran's Charter of Patient Rights in 2009 stipulates the provision of patient-friendly information (12).

Patients want accurate and reliable information about their diagnosis, treatment options, and potential outcomes (13). Telling the truth allows patients to understand their healthcare options, thereby improving treatment outcomes (14). This empowerment helps them to make informed decisions and feel more in control of their situation (15). Therefore, the current common view is that medical information should be disclosed to patients and/or their families to strengthen trust, reduce harm, increase satisfaction, and minimize legal conflicts (16).

The ability to communicate the truth is critical for healthcare providers (17). The quality of the delivery of bad news is directly related to psychological and social adjustment, satisfaction with care, health care outcomes, and patient anxiety and depression (18). Effective truth-telling communication requires a multidisciplinary approach (19). It is not solely the responsibility of doctors but is a process that includes nurses, social workers, and even families and patients themselves (20). This process involves preparing the patient and their relatives, clarifying the existing conditions, and helping them to understand the condition and its implications, and nurses have an important role in all of these steps (19).

While caring for the patient's physical health, their mental and social health is often neglected, leading to increased anxiety. Truth-telling is a key component in encouraging the patient to participate in decision-making, which builds trust and fosters honest communication (5, 21). However, patients and family members may exhibit different reactions to truth disclosures because of different beliefs, customs, and cultures, which complicates the problem (22). Additionally, in some cases, health care providers and families may jointly decide to withhold detailed information to protect the patient. Girgis et al. suggested that comparing patient perceptions with those of various healthcare providers, such as nurses, physicians, and other professionals, can help assess the appropriateness of truth-telling protocols. Each group provides valuable insights into what constitutes quality care in the context of the patient-healthcare provider relationship (23). Therefore, the first step in creating relevant procedures for Iranian culture is to look at the views and preferences of those involved in health disclosure in Iran, namely healthcare providers, patients, and family members. One of the best ways to investigate attitudes about a person's culture or lifestyle is to conduct qualitative research (24).

2. Objectives

This study was conducted to gain insight into the challenges associated with truth disclosure in patient care through the experiences of healthcare providers, patients, and families.

3. Methods

3.1. Design

This qualitative study was conducted using a thematic analysis method. The qualitative approach identifies the patterns or themes in the data of a study, and then analyzes and reports them (25).

3.2. Participants and Setting

This study included participants from four groups—patients, family, physicians, and nurses—from the intensive care units of four large, high-volume hospitals affiliated with the Shahid Beheshti University of Medical Sciences located in the Tehran province of Iran. Purposive sampling was used to select participants whose experiences were consistent with the research questions and who had a diverse range of demographic, occupational, and clinical characteristics, including age, gender, disease, and role (26).

Inclusion criteria for patients were: Having a definitive diagnosis of disease, knowing their diagnosis, and having no cognitive impairment. Inclusion criteria for family members were: Having a close relationship with the patient, the patient and themselves knowing the diagnosis, and having no physical or cognitive problems. The inclusion criteria for physicians and nurses were having at least one year of experience treating and caring for patients with unfavorable diagnoses (e.g., cancer) and having experience with truth disclosures to patients and families. The physicians selected for the study included urologists, oncologists, and critical care specialists.

3.3. Data Collection

Study data were collected from February 2022 to November 2023 using semi-structured, in-depth interviews with participants. All interviews were conducted in a private room at the hospital. The time and place were determined with the consent of the participants. Each interview lasted 45 to 60 minutes. The process of participant recruitment and data collection was continued until data saturation was achieved (no new information or categories emerged from the data) (26).

All interviews were conducted and recorded by one of the researchers (S.K.H.) with the written informed consent of the participants. The interviews started with general questions to establish trust between the interviewer and participant, then proceeded to more detailed questions about truth disclosures based on the participant's initial answers. Examples of the interview questions asked of each group of participants are shown in Table 1.

Table 1. Example Questions Asked in the Interviews

Physician and Nurse	Patient	Family Member
1. How do you communicate the condition of the disease to the patient and their family?	1.When were you first diagnosed with your illness? How? By whom?	1. When was the patient first informed about their illness? How, and by whom?
2. Have you ever not told the patient or his family the truth?	2. How do you think the patient should find out about the diagnosis of their illness?	2. How do you think the patient should be informed of their diagnosis?
3. Who do you tell about the patient's condition?	3. Who should be present when disclosing the news of an illness?	3. Who should be present when receiving bad news?
4. What conditions and circumstances do you provide when disclosing the diagnosis to the patient and their family?	4. Were you satisfied with the way it was revealed? Please provide more details	4. What words and expressions should be used to deliver bad news?
5. Who do you think should be present when disclosing a diagnosis?		

3.4. Data Analysis

A total of 27 interviews were conducted and included in the study. The data were analyzed using the thematic analysis method following the five-step thematic analysis process described by Fereday and Muir-Cochrane (27). Briefly, the texts were transcribed and read, followed by identifying key phrases and making initial notes. The coding process was done manually, and the codes were categorized into themes and sub-themes. The researchers then reviewed the codes that formed the themes and sub-themes and assessed their alignment with the categories and internal consistency. Finally, the researchers applied definitions and categories to the final themes and sub-themes. This process was carried out by two researchers in the team, and all members of the study team agreed on the final themes and sub-themes.

The trustworthiness of the data was assessed using the criteria of Lincoln and Guba (1985) (28). We improved confirmability by recording all research activities and analysis notes in parentheses and maintaining a clear, easy-to-follow audit trail. To strengthen the credibility of the data, codes, subcategories, and categories, we conducted a debriefing and peer review. The extracted codes and results were retrieved and shared with participants to confirm the congruence of the codes with their experiences. We achieved reliability by involving multiple researchers in the data analysis. Transferability of results was promoted by recruiting participants with different demographic characteristics and diverse experiences.

3.5. Ethical Considerations

Data collection was conducted after obtaining approval form the ethics committee of University of Rehabilitation and Social Health Sciences (certification code IR.USWR.REC.1400.204). All participants signed an informed consent form after being informed of the objectives of the study, information confidentiality, and the right to withdraw from the study at any time. It is important to note that this study is part of a larger research project.

4. Results

The study involved 27 participants, out of which 12 were nurses (8 ward nurses, 2 head nurses, and 2 nurse supervisors), 4 physicians, 4 patients, and 7 family members. The participants were aged between 27 and 46 (mean age 37) and had 3 to 26 years of work experience (mean 13 years). The family members ranged in age from 27 to 71 years (mean age 39 years). The diagnoses of the patients participating in the study were kidney cancer (n = 2), bladder cancer (n = 1), and colon cancer (n = 1). More detailed characteristics are presented in Tables 2. and 3.

After analyzing the 27 interviews, the first 750 codes were extracted and merged based on their semantic approximation. Three main themes and eight sub-themes were identified. The main themes were: (1) Truth shock, (2) Secrecy during treatment and recovery, and (3) The patient's right to information (Table 4).

Table 2. Characteristics of the Health Care Provider Participants

No	Education level	Gender	Age (y)	Position	Work Experience, (y)
HCP1	Bachelor	Female	31	Nurse	10
HCP2	Bachelor	Male	29	Nurse	6
HCP3	Bachelor	Male	46	Nurse	24
HCP4	Masters	Female	37	Nurse	13
HCP5	Bachelor	Male	43	Nurse	18
HCP6	Masters	Female	37	Nurse	19
HCP7	Bachelor	Male	29	Nurse	3
HCP8	Bachelor	Male	27	Nurse	3
HCP9	Bachelor	Male	50	Head nurse	26
HCP10	Bachelor	Female	40	Head nurse	18
HCP11	Bachelor	Male	41	Clinical supervisor	20
HCP12	Masters	Male	43	Clinical supervisor	23
HCP13	Specialist	Male	27	Urologist	3
HCP14	Specialist	Female	38	Urologist	6
HCP15	Specialist	Female	36	Oncologist	6
HCP16	Specialist	Male	38	Critical care physician	10

Table 3. Characteristics of the Patient and Family Member Participants

No	Type of Disease	Marital Status	Education Level	Gender	Age (y)	Relationship
P1	Colon cancer	Married	Masters	Male	34	Patient
P2	Kidney tumor	Married	High school	Male	69	Patient
P3	Bladder tumor	Married	High school	Male	71	Patient
P4	Kidney tumor	Single	High school	Male	27	Patient
FM1		Married	High school	Female	36	Wife
FM2		Married	Bachelor	Male	42	Father
FM3		Married	Bachelor	Male	38	Father
FM4		Married	High school	Female	45	Mother
FM5		Married	Bachelor	Female	31	Wife
FM6		Married	Bachelor	Female	45	Daughter
FM7		Single	High school	Female	37	Daughter

Table 4. Themes and Subthemes Extracted from the Participants' Experiences

Main Theme	Subtheme
1. Truth shock	Patients' inability to face the truth; Family's inability to handle the truth
2. Secrecy during treatment and recovery	Withholding critical information from patients and families; Family confusion about the patient's condition; Family preventing truth disclosure to the patient; Family fear of truth's impact on the patient
3. Patients' right to information	Lack of patient awareness of their rights; Importance of informing patients about their condition

4.1. Theme 1: Truth Shock

The first main theme, Truth shock, had two sub-themes: "Patients' inability to face the truth" and "family's inability to handle the truth". This theme included codes related to denial, fear, and other negative emotions and reactions related to learning distressing information about a patient's condition.

4.1.1. Patient's Inability to Face the Truth

When health care providers decide to disclose the truth to the patient, the patient may not accept the truth because they fear the reality and its consequences, such as losing individual independence, becoming a burden to others, feeling close to death, and separation from the family.

"The physician provided the patient with the truth, but the patient remained skeptical, leading to constant inquiries about the physician's issue." (P1, nurse)

Some patients do not try to understand the truth because they fear being confronted with it.

"The doctor did a good thing by not telling me the truth." (P25, patient)

When receiving bad news they are not psychologically prepared for, the patient may strive to maintain their mental health by denying the disease. When the wall of denial collapses, it can give way to anger, guilt, and hatred.

"When patients understand the truth, they say, 'God, why me?' I feel guilty." (P20, patient)

Despite the state of shock and denial, the patients gradually accepted the truth and sought treatment solutions due to their family, religious beliefs, and interaction with the peer group.

"Because of my wife and talking to similar patients, I trusted God and started chemotherapy." (P20, patient)

4.1.2. Family's Inability to Handle the Truth

When healthcare providers decide to tell the patient's family information about the disease, prognosis, and treatment or deliver news of the patient's death, the family does not believe the information, reacts violently, and tries to deny the truth.

"When I tell the truth, the families don't believe me. They show sharp reactions." (P8, physician)

Sometimes, family members do not accept the truth and react violently despite prior preparation:

"Although we had given all the necessary information to the families in advance, the death of the patient led to chaos in the ward, threats, and the throwing of stones at the attending physician" (P4, supervisor)

The healthcare providers in our study stated that these mental states and reactions are not the same in all patients and their families, and differ based on culture, literacy level, sociodemographic characteristics, and individuals' level of understanding and personality.

4.2. Theme 2: Secrecy During Treatment and Recovery

Some patients and families member participants reported that healthcare providers did not communicate the truth to them, while healthcare providers stated that families tried to hide the truth from patients. This theme included codes related to health care providers not disclosing the truth to patients and families, family members not wanting truth disclosed to the patient to protect them, fear of the impact of the truth, and families being confused.

4.2.1. Withholding Critical Information from Patients and Families

Healthcare providers may try to avoid telling the truth for reasons such as inability to predict reactions or fear of unfavorable reactions, lack of knowledge and ability to disclose the truth, concern that the patient and family will not understand, and insufficient information about the disease and the treatment process:

"When patients and families ask me for the truth, I don't disclose the diagnosis because they tend to react with blame and make a lot of noise about why it happened." (P1, nurse)

Healthcare providers often try to hide the truth from the patient and instead inform the patient's family because of consideration for the patient's mental condition and the insistence of the family.

"The physician removed my kidney, but gave me no information." (P24, patient)

Sometimes health care providers are unwilling to tell the truth due to a lack of training and skills:

"Unfortunately, the physicians and nurses in the education and treatment centers are not trained." (P19, supervisor)

4.2.2. Family Confusion About the Patient's Condition

Family members also reported that healthcare providers did not communicate the truth clearly and comprehensively to them and that they were confused about their patient's condition:

"The physicians do not clearly communicate the diagnosis of the disease to the patient or the family." (P16, family member)

"The doctor does not come to explain to us what happened and what can be done. We don't understand anything, they don't talk to us, and we don't know what to do. We want the doctor to tell us what he did and what is wrong; we are confused." (P11, family member)

Sometimes, instead of answering patients' and family members' questions, healthcare providers give misleading and false information to unethically promote false hope:

"The false information the physicians gave me has caused my son's disease to progress." (P18, family member)

Physicians and nurses may not convey comprehensive information to families due to reasons such as not having enough time, excessive workload and stress, or having insufficient information about the disease themselves.

"Whenever we seek information from physicians and nurses about our patient's condition, they claim they don't have time to discuss it. Consequently, we are unsure about who to approach, and this has left us feeling extremely perplexed." (P24, family member)

"We are so busy that we don't have enough time to provide information about the patient's illness to the families." (P5, physician)

Moreover, when the families are disappointed with the communication from health care providers, they turn to the internet to get comprehensive information about the disease and prognosis and unreliable sources such as social media to find answers to their questions.

"When we don't find answers to our questions, we search the internet to find answers and understand." (P24, family member).

Sometimes there is a conflict between the information that the doctor and nurse give to the patient and the family, and this also causes discomfort and confusion for families:

"We nurses always ask the physicians in charge of the patient to give the correct information to the companions, because often the physicians do not give enough information." (P10, nurse)

Some members of the care staff do not accept the responsibility of telling the truth and instead assign it to other members, potentially confusing and frustrating the patient and family:

"When I couldn't find my father's physician to get information about the disease, I went to the nurse and asked him, but he didn't answer and said, 'I don't know, go and ask the physician yourself.'" (P24, family member)

4.2.3. Family Preventing Truth Disclosure to the Patient

Traditional social beliefs and cultural habits often lead families to make decisions about patients, prevent healthcare providers from sharing accurate information about the disease with the patient, and provide incorrect information in response to the patient's curiosity about their illness.

"The family does not agree to us telling the patient that he has cancer." (P7, head nurse)

"My father had cancer of the larynx and bladder. We even told the care staff not to say anything to my father." (P23, family member)

4.2.4. Family Fear of the Truth's Impact on the Patient

Although the families had various reasons for not wanting their patient to be aware of their disease, a specific reason that emerged as a sub-theme was fear of how learning the truth would affect the patient. Families believe they know enough about their patient's mental and emotional state to decide to withhold the truth.

"My father had cancer, and we didn't want him to know that he was in a situation he couldn't bear." (P18, family member)

Sometimes, family members are worried that the care staff will misrepresent the facts to the patient, so they do not allow healthcare providers to inform the patient about their condition.

"The staff inform the patient about the disease suddenly and in inappropriate conditions, so our preference is that they do not announce it at all." (P23, family member)

4.3. Theme 3: Patients' Right to Information

In this theme, healthcare providers expressed that they respect patients' right to know the truth and believe in the importance of educating them about their legal rights, ensuring they understand their rights and have the information they need to make rational decisions and maintain their autonomy.

4.3.1. Lack of Patient Awareness of Their Rights

Some patients are not aware of their legal rights to receive information and determine their own care, and as a result, health care providers and family often decide for them.

"The patient who comes to the hospital does not know what their rights are." (P7, head nurse)

Sometimes patients and families attribute what happens to them to fate and do not seek more information.

"We had a 37-year-old patient in the hospital who underwent bladder stone crushing surgery and died. His mother was crying and his father told his mother not to cry, this is the fate of our son, instead of pursuing the cause of death." (P5, physician).

4.3.2. Importance of Informing Patients About Their Condition

The healthcare providers in the study emphasized that patients have a right to timely information that enables them to make informed decisions, maintain their life course, and actively participate in treatment.

"I try to explain to those more receptive about their disease status. This is good, and they have the right to know the truth… Even a person who doesn't have a chance… I don't give them false hope. There is no problem; at least they have time to think." (P8, physician)

They also expressed that the necessary mechanisms should be put in place so that the patient does not suffer more and families do not insist on making decisions for the patient. The patient's rights should be honored, and they should be supported to accept the bad news and continue on the treatment pathway.

"Now is the time to inform the patient and family of their legal rights so that they can make a more informed decision about what to do. Families should know that they should not insist on hiding the truth and respect the patient's rights." (P27, physician)

5. Discussion

This study aimed to provide insight into the challenges of truth-telling in the clinical setting through the experiences of physicians, nurses, patients, and families. The results were presented in three main themes: "truth shock", "secrecy during treatment and recovery", and "patients' right to information".

Truth shock was one of the main themes of this study. This is consistent with a study by Ebrahimi et al. showing that when the patient learns the truth, the first phase is shock and inability to believe or accept they have such a disease. In this stage, the patient is attempting to cope with denial (29). The patients in this study attributed this shock to a lack of prior preparation, the unpleasant nature and sudden announcement of the news, and the distressing implications of the truth, such as the loss of their independence. In some studies, patients with cancer described hearing the truth as a painful experience that is difficult to bear and used denial as a defense mechanism (12). The stage of confusion when first confronted with a diagnosis can be seen as a stage of shock, denial, and non-acceptance of the disease (7).

Accepting the disease is a process that patients must face and ultimately accept (30). In this study, after passing through the shock stage, patients eventually accepted their disease and its treatment because of various factors such as religious beliefs, being married, and interacting with patients similar to themselves. However, healthcare providers may not pay enough attention to these factors when disclosing the truth. The results of a study showed that medical professionals and nurses should use positive expressions like “everything is in God’s hands” and “God is merciful” to emphasize the positive impact of spiritual and religious beliefs on psychological states (31). Acceptance of a disease can also differ based on factors such as age, gender, living conditions, and lifestyle (32).

Although patients may deny the truth at first, over time they still want this information in order to make the right decision to continue their treatment. In one study, 96% of patients stated that they would want to be informed of a definitive diagnosis of diseases such as cancer (21). Therefore, healthcare providers should not let the possibility of negative initial reactions be a barrier to truth-telling. Baile et al. emphasized the importance of employing techniques to reduce the emotionally distressing effects and feelings of isolation that patients experience at the time of truth disclosure (33). The patients in our study believed that receiving support from a variety of sources, such as a multidisciplinary team and their family, could help to bring about calmness during the sensitive stage of facing reality. Stiefel and Krenz highlighted the benefits of having a psychologist or psychiatrist present, as they can provide patients and their families with psychological and emotional support (34).

Healing through secrecy was the second main theme of this study. Our results suggest that healthcare providers hide the truth from patients for various reasons and choose to inform the family instead. The results of a study by Ibn Ahmadi et al. also emphasized families’ insistence on hiding the truth (35). In Islamic countries like Iran, the primary focus is to prevent psychological stress for patients, with families playing a crucial supportive role (9). This is consistent with the results of the present study. Another study showed that two-thirds of doctors preferred to share the diagnosis with the patient’s relatives (20). Sometimes the patients themselves want the family to be informed. In an Iranian study, 63% of patients wanted to have family members present during truth-telling (21). However, this rate was lower in Western countries, with 40% of health care providers in Ireland (36), 53% to 57% in Australia (37), and 61% in Portugal tending to share bad news with family members or tell the patient in their presence (38). Reducing the patient’s hope and stirring up fears are the main reasons why families refuse to tell the truth (7). Predicting patients’ reactions to unpleasant news has made it challenging for medical staff to deliver the truth, particularly in countries with diverse opinions, customs, cultures, and personalities (12). Although medical ethics clearly forbids lying to patients, it is not recommended to always disclose the entire truth. It is necessary to consider the personality, culture, religious beliefs, and ethnic traditions of individuals when conveying information (5).

In the present study, families were very important in the decision-making process regarding patient care and truth disclosure. The results of similar studies also showed that family plays a crucial role in patient care, treatment decisions, and adaptation to the consequences of disease in Eastern Europe and Asia, providing essential support and guidance (2, 7). The protective function of the family can have many advantages, but in some cases it becomes a barrier to truth-telling. Family members may insist that health care providers withhold certain information from the patient. Families in this situation should understand the need to be honest with the patient, as well as the consequences of not informing them (39). Healthcare providers in Islamic countries can help family members gain insight into truth-telling by explaining patient rights to information and autonomy (2).

Another reason for nondisclosure among healthcare providers is a lack of knowledge and skills regarding truth-telling. The literature also showedthat healthcare providers are aware of their need for training about delivering bad news to patients, as well as clinical guidelines on how to do so (40, 41).

We also found in this study that healthcare providers gave patients inaccurate information about their disease to encourage hope and morale. However, patients emphasize the importance of their physician being responsible, truthful, and communicating in clear and explicit language (21). Patient dissatisfaction stems from unsympathetic and disappointing disclosure of facts, while most bad news protocols highlight the importance of empathy, realistic hope, and emotional support (42).

In contrast, the healthcare providers in our study emphasized the patient's right to know the truth, expressing a belief that the patient-physician relationship is based on patient rights. One study reported that failing to adhere to one's duty to observe patient rights can lead to diagnostic errors and put the patient's health or life at risk (9). Of course, it is also essential to observe the mental and psychological condition of the patient and assess their readiness to hear the truth (21, 43). Knowing the truth is a patient's right and enables them to practice autonomy (9). Therefore, the provision of this information by health care providers to the patient and those around him must be conducted by the principles of general ethics and professional medical ethics (44). Nurses play important roles as educators, consultants, facilitators, and supporters in truth disclosure (45). In addition to the important role of family and spirituality in supporting the patient to accept the truth, the supporting role of healthcare providers should not be ignored.

5.1. Limitations Of the Study

The sociocultural differences between Tehran and other Iranian cities may limit the generalizability of the findings of this study, which was conducted in educational and medical institutions in Tehran. Nevertheless, we used a purposive sampling method to include participants with different sociodemographic and clinical characteristics, and the sample size was appropriate for a qualitative study. One of the strengths of this study was the inclusion of interviews with various participant groups, including patients, their families, physicians, and nurses.

5.2. Conclusions

There are different opinions about telling the truth. Currently, it is still common practice in some places to hide the truth from patients, give false hope and misinformation, and not have appropriate timing for truth disclosures. Various barriers to truth-telling stem both from health care providers and the patients' families. Our results suggest that key aspects of effective truth-telling in Iranian culture and society include planning and prior preparation of patients and families, paying attention to patients' preferences and requests, using cultural sensitivity, explaining the importance of truth-telling to families, and including spiritual and religious elements during truth disclosure. Therefore, health care providers must develop an effective, culturally appropriate disclosure strategy taking into account the importance of communication skills and the legal and ethical considerations.

Footnotes

Authors' Contribution: S. K.: interviews, data analysis, and preparation of manuscript; G. C.: data analysis and editing of manuscript; M. A. H., F. M. S., and M. F. K.: data analysis and approval of the final version of the manuscript.

Conflict of Interests Statement: The authors declare that they have no competing interests.

Data Availability: The dataset in this study are not publicly available due to ethical restrictions to maintain the participants' anonymity.

Ethical Approval: Approval to conduct the study was obtained from the Central Institutional Review Board (IRB) of the University of Rehabilitation Sciences and Social Health and had a Central IRB log number of IR.USWR.REC.1400.204 , dated November 20, 2021.

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