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Disclosing Bad News to Patients: Balancing Culture and Autonomy

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Abstract

Effective communication between healthcare providers and patients is a cornerstone of medical practice ethics. Delivering bad news, which would significantly alter a patient's perception of their well-being, varies across cultures. While Western medical ethics prioritize patient autonomy, many countries in the Middle East and North African (MENA), including Libya, adhere to a family-centered approach, that often involves withholding bad news from patients with the intention of minimizing emotional distress. This paper explores the ethical and cultural dilemmas of truth disclosure, highlighting the role of inadequate training in soft skills, and proposes a culturally sensitive framework to balance patient autonomy with social customs.

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Best Available Evidence

Cultural Variations in Truth Disclosure

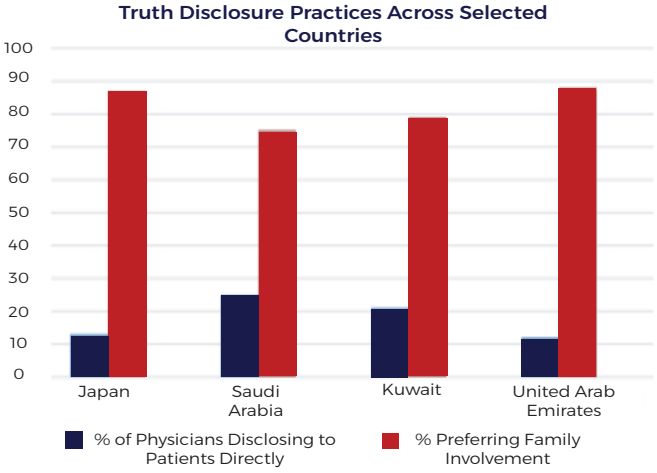
Globally, truth disclosure practices vary based on cultural values and ethical priorities. In the United States, the United Kingdom, and Canada, ethical guidelines prioritize the principle of autonomy, ensuring that patients are fully informed about their diagnosis and treatment options.[1,2] Studies indicate that in these regions, the majority of patients are directly informed of serious diagnoses, such as cancer or terminal illnesses, even if it was life threatening.[3]

However, a contrasting approach is observed in other regions. For example, in Japan, only around 13% of physicians disclose serious diagnoses, such as cancer, directly to patients.[3] Similarly, studies in the MENA region reveal that 75% of Saudi physicians prefer to inform a family member before letting the patient in on any information. In Kuwait, 79% comply with family requests to withhold serious diagnoses from patients.[3] A survey conducted in the United Arab Emirates found that 88% of physicians believed it was justified to disclose information to families rather than to patients.[4] These statistics raise concerns about whether these practices stem solely from cultural norms or whether insufficient training in medical ethics plays a role.

Challenges in Medical Training

Medical training has traditionally prioritized technical and scientific knowledge over communication skills. This results in many physicians reporting discomfort and stress when being put in situations such as delivering bad news.[5] A large-scale international survey involving over 10,000 participants revealed that only one-third of medical trainees had received formal training in "breaking bad news".[5] Similarly, a separate study conducted in Iran found that 35.5% of medical residents lacked training in this critical skill.[6] This lack of education contributes to physician hesitation and often results in reliance on family members as intermediaries in cultures where autonomy is less prioritized. It is crucial to recognize that many doctors report delivering bad news as difficult and stressful, highlighting the need for improved training in this area.[7]

In Libya, formal training in communication and ethical decision-making remains limited causing many medical students and residents to be unprepared to handle emotionally sensitive conversations and reinforcing the existing cultural norm of non-disclosure. This was



frequently justified by the belief that these skills were less important in a cultural setting where family-oriented practices prevailed. Nevertheless, this viewpoint may amplify physician unease and hesitance to interact directly with patients. Recent WFME-guided reforms in medical education in the country with the introduction of structured training in soft skills such as breaking bad news, patient-centered communication, and ethical reasoning will significantly enhance the ability of Libyan graduates to navigate these challenges while respecting cultural values.

Proposed Solution: Balancing Autonomy and Culture

A culturally sensitive approach to breaking bad news should integrate both ethical principles as well as local traditions. One potential solution is by the application of therapeutic privilege, as described in the AMA Code of Medical Ethics, as permitting doctors to withhold information from patients if disclosure is deemed harmful to the patient. However, the AMA stresses that these decisions should only take place with the patient's consent and approval beforehand.[2] How this is done would be by allowing the patient to make the decision beforehand whether they prefer to receive information directly or have it communicated through family members.

For example, a patient could be asked:

"Your relatives have requested that we provide them with your medical results first. Would you prefer this, or would you like to receive the information directly?"

This method ensures that the patient's autonomy is respected while allowing for culturally appropriate family involvement.

Addressing training deficiencies is essential as medical curricula should incorporate formal training on communication skills, cultural competency, and ethical decision-making. Postgraduate programs and continuing medical education (CME) initiatives should reinforce these skills, equipping healthcare providers with the confidence for essential communication skills as well as the ability to manage difficult conversations effectively.

Conclusion

The challenge of delivering bad news lies in balancing patient autonomy with deeply ingrained family-centered traditions. While family involvement is a significant aspect of care in many societies, patients should be able to retain their right to decide how and when they receive medical information, medical treatment, radiation and/or surgical interventions. Implementing structured training programs for physicians and employing a patient-centered approach, where individuals can determine their preferred method of disclosure, can help bridge the gap between ethical principles and cultural expectations. Moving forward, a shift towards better education in communication skills will be essential in ensuring ethical, compassionate, and culturally sensitive healthcare practices.

To inform these efforts, we may need a study to evaluate both the depth of communication skills training among physicians as well as their current attitudes toward truth disclosure, particularly across different cultures and physicians age groups. Younger doctors are potentially influenced by globalized medical trends and may be more receptive to patient autonomy, while older doctors might favor a more traditional or family-centered practice due to limited prior training. This research could highlight gaps and generational differences, guiding targeted interventions. Moving forward, a shift towards implementing the recent education reforms in soft skills is essential in ensuring ethical, compassionate, and culturally sensitive healthcare practices.

Disclosure Statement
The authors declare no conflicts of interest.

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