



Exploring the Use of White Lies in Patient Care Process by Triangulation Method

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Abstract

Introduction: Being in a situation to use white lie is a challenging experience for healthcare providers. Recognizing the situations that facilitate white lies and providing solutions to them are effective in providing patients with the truth about their treatment and reducing white lies. The objective of this study was to explore the experiences of patients' families, nurses, and physicians in using white lies during care process.

Methods: This study, with a triangulation approach, was conducted in 2018 at the hospitals affiliated to Tehran University of Medical Sciences. Data were collected in two qualitative and quantitative phases from three sources including patients' families, nurses, and physicians. In the quantitative phase, 300 samples were selected by random sampling to complete a researcher-made questionnaire. Descriptive statistics and frequency tables were used to analyze the quantitative data with SPSS (version 16). In the qualitative phase, 30 individuals from above-mentioned sources were selected by purposive sampling to participate in the face-to-face and semi-structured interviews. Data analysis in qualitative phase was done by Graneheim and Lundman's conventional content analysis with MAXQDA software (version 12). In the final step, quantitative and qualitative data were compared and interpreted.

Results: The findings of qualitative phase were summarized in four categories (inappropriate situation, patient expediency, surrounding frameworks, and communication bridges) and eight subcategories. In the quantitative phase, the highest score was related to the category of patient expediency. It was also found that the findings of qualitative and quantitative phases were consistent and complementary to each other.

Conclusion: According to the findings, the use of white lies was for patient's benefit and to create an appropriate situation for telling the truth. In this regard, providing appropriate guidelines in accordance with the culture, therapeutic goal, and understanding of patients can enhance caregivers' skills in rendering information to patient. The findings of this study can be used as a guide in other qualitative and quantitative researches regarding the use of white lie in patient care and its consequences.

Keywords: White lie, Truth-Telling, Care, Triangulation

Introduction

One of the most basic patient rights, which is accepted all over the world, is the right to receive true information. The final version of the Iranian Patient Rights Charter states that, information that should be provided to patients include diagnostic and therapeutic methods, strengths and weaknesses of each method and its potential complications,

prognosis, and all other information that can affect patient's decision-making (1); moreover, disclosure of the truth based on patient's own will regardless of age, gender, and social/cultural background should be considered as a right (2). An important ethical principle indicates that the truth should first be presented to patients themselves, and if they agree,



it can also be provided to their relatives (3). Families in Iran ask physicians not to reveal the truth to patients in order to protect them (4), and also patients' families believe that knowing the truth can have a negative impact on patient recovery. They usually know about diagnosis and treatment process and make decisions on behalf of the patient since they worry that patient is too weak to handle the truth (5). This is while, most patients wish to receive complete medical information and very few of them think otherwise (6).

Although it is the duty of physicians to disclose the truth to patients and provide them with information (4-9), it undoubtedly requires the cooperation of all members of treatment team, including nurses (10). Although service providers are aware that rendering the truth about treatment is a patient right, they sometimes resort to the use of so-called white lies (11).

By definition, white lies are intended to be expedient and contain part of the truth, but their consequences are not important and are just used to maintain relationships or reduce the suffering of patients (12). Regarding the use of lies in patient care process, there is a great deal of evidence in the history of Greek medicine that show Greek physicians did not give information to patients or gave wrong information in order to make them accept the treatment (13). The use of white lies has been reported in the care of patients with cognitive impairments (14,15) and malignancies (16-18) or child care (19).

In line with the use of white lies in patient care, James et al in their research concluded that lying is seen at all levels of care process and 96.4% of healthcare staff use it as a communication strategy (20). In the study by Rejno et al, nurses were reported to manipulate the truth and use white lies (21). In a study conducted in Iran, Montazeri et al found that about 80% of physicians did not tell their patients the truth about diagnosis (22). In the study by Atrak entitled: "Lying to patient with a benevolent motivation", it was indicated that telling

patients the truth increased their anxiety and despair, and led to sadness, depression, fear, and sometimes suicide (1). Most studies have been conducted with the aim of examining the attitude of target groups towards telling the truth in a form of quantitative or review study. In addition, they have used only one of the care sources (patients' families, nurse, or physician). No study was also found to use both qualitative and quantitative methods to examine the experiences and perspectives of care providers in the cultural context of Iran.

Investigating the causes of white lies in patient care from different sources and directions is one of the available strategies for deeper understanding of the issue. To achieve this, the experience of physicians who are responsible for the diagnosis and treatment of patients, caregivers who are in constant contact with the patients, and patients' families and other caregivers need to be analyzed. Therefore, triangulation method was considered as the conceptual framework and theoretical model in current research to gather the most comprehensive information available. This approach is a well-known approach for obtaining different but complementary data on the same topics. In this way, the researcher executes qualitative and quantitative data in the same period of time with equal intensity. The researcher also uses this approach when he or she attempts to compare results or is interested in validation or support of the data of qualitative phase by the data of quantitative phase (23). Therefore, this study aimed to analyze the use of white lies in patient care process by triangulation method in order to present solutions to rendering true information to patient.

Methods

This study was conducted using data triangulation based on Creswell and Plano-Clark's method, both qualitatively and quantitatively (23). Data were collected from three sources of patients' families, nurses, and physicians by both questionnaire and interview (Figure 1).

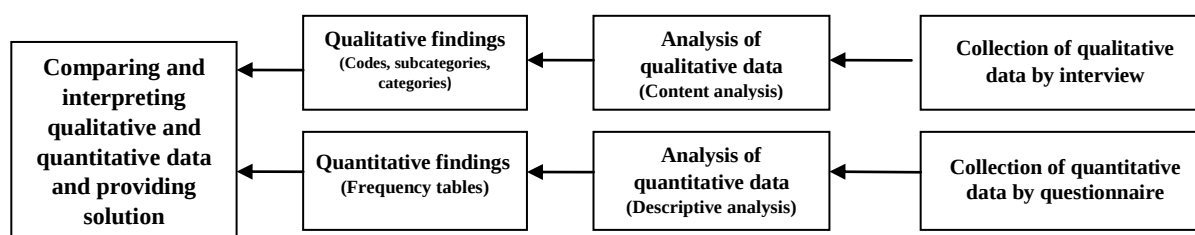


Figure 1. Triangulation design of the study

Qualitative phase

Data of qualitative phase were analyzed using conventional content analysis. By this method, individuals with rich experiences about the subject under study were selected by purposive sampling method. The purpose of the study was explained to the participants prior to the interview and if they had experience in this field, they were invited to share their experiences. The inclusion criteria in the qualitative phase were being a Persian speaker, having aural and oral health, being willing to share experiences, and participating in the study voluntarily. Therefore, physicians and nurses with more than one year experience of working in hospitals affiliated to Tehran University of Medical Sciences and the families of patients treated in the hospitals were selected to participate in the study. Patients' families in this study referred to, "those responsible for the direct care and follow-up of the patient", hence, according to this definition, families who were providing care for patients with a chronic illness for more than 6 months were selected.

In-depth, semi-structured, and face-to-face interviews as well as two questionnaires were used to collect the data related to the experiences of physicians, nurses, and patients' families. Each interview lasted about 30-60 minutes and all interviews were recorded and transcribed verbatim. It was also tried to understand what information were more important to patients, and why some information were not provided to patients? Other questions included: "Have you ever been in a situation where you cannot tell the truth or disclose all information about the treatment? Have you experienced the use of white lies during patient treatment? What was the experience like?"

Probing questions such as "can you explain more?" and "what do you mean?" were also used during the interviews. The interviews were analyzed simultaneously with data collection based on Graneheim and Lundman's method in five steps: 1) writing the entire interview immediately after each interview, 2) reading the interview text several times to reach a general sense of understanding, 3) determining semantic units and primary codes, 4) classifying similar codes into more general classes, and 5) identifying the latent

contents in data (24) (Figure 2).

The coding process was done by MAXQDA software version 2007. To ensure the validity and trustworthiness of the data, Lincoln and Guba's criteria of credibility, transferability, dependability, and confirmability were used (25). Credibility of the data was determined by confirming the accuracy of statements made by the participants with the texts. The researcher also tried to have a long-term engagement with the participants to gain their trust and understand their experiences through appropriate communication. Confirmability of the findings was assured by observers' review of the interview transcripts, related codes, and emerging categories, and using their comments and opinions in the data analysis. Dependability of the findings was achieved by writing the interviews as soon as possible and providing similar opportunities for the participants (26).

Quantitative phase

To collect data in the quantitative phase, a demographic information questionnaire (including age, sex, and marital status) and a researcher-made questionnaire on the use of white lies in patient care process, designed based on relevant literature (27-29), were used. The white lie questionnaire consisted of 25 questions in a five-point Likert's scale ranging from strongly agree (5) to strongly disagree (1).

The white lie questionnaire was given to 10 experts (7 with Ph.D. in nursing and 3 with Ph.D. in biostatistics) to determine its quantitative content validity. Content validity ratio was used to evaluate the qualitative content validity and content validity index was used to ensure that tool's questions have been designed correctly for measuring the variables. To determine the content validity of the questionnaire, the responses were calculated based on the content validity ratio (CVR= 0.76). The questionnaire was also given to the 10 above-mentioned experts to calculate its content validity index (CVI) (0.84). To examine the reliability of the questionnaire, the internal consistency of questions was assessed using Cronbach's alpha coefficient. For this purpose, the questionnaire was given to 30 participants with the same characteristics as the research samples and the Cronbach's alpha coefficient was calculated to be 0.83.

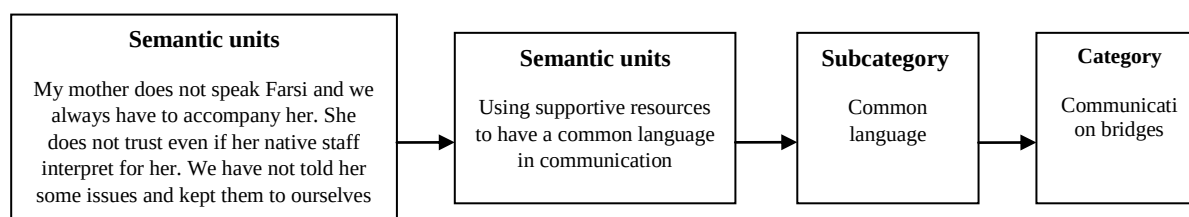


Figure 2. Summary of the process of extracting subcategories and categories from semantic units (an example)

The inclusion criterion for the quantitative phase of this study was being a physician or a nurse with more than one year of experience working in hospitals affiliated to Tehran University of Medical Sciences. Families of patients with chronic diseases who were caring for their patients directly were also selected to participate in this study. A pilot study was conducted to determine the sample size. Considering 90% test power, 5% error, and $r = 0.5$, a total of 309 individuals were selected by simple random method to take part in this study. An explanation on how to complete the questionnaires was also provided to the participants. It should be noted that out of 309 samples, 300 completed the questionnaire accurately and returned it. Data were analyzed by SPSS-16 software using descriptive statistics (mean and standard deviation).

The present study was performed at the hospitals affiliated to Tehran University of Medical Sciences. To observe ethical considerations in this study, a research permit was obtained from the Ethics Committee of Tehran University of Medical Sciences. Moreover, all participants were first informed about the purpose and method of the study, and then an informed consent was obtained from them. The participants were told that participation in the study was voluntarily and they could withdraw from the study at any time. An emphasis was also placed on protecting the audio files and anonymity of the participants. The participants were also assured of the confidentiality of information and disclosure of results only when requested by the participants.

Results

The findings of this study are presented in two qualitative and quantitative parts.

Results of the qualitative phase

In the qualitative phase, the participants included nine physicians (three oncologists, one gynecologist, two emergency physicians, two internal specialists, and one general surgeon), twelve nurses (two supervisors, five medical-surgical nurses, two emergency room nurses, and three ICU nurses), and nine family members (family of a child with Hodgkin lymphoma and eight adults with diseases such as colorectal cancer, advanced multiple sclerosis, stroke, congestive heart failure, leukemia, melanoma, renal failure, and

lupus). The findings of qualitative phase were classified into 4 categories, 8 subcategories, and 403 initial codes. These categories included inappropriate situation, patient expediency, surrounding frameworks, and communication bridges (Table 1).

Results of the quantitative phase

In total, 112 nurses (63% female and 78% married) with the mean age of 32 ± 4 years, 91 physicians (56% male and 89% married) with the mean age of 42 ± 2 years, and 97 family members (86% male and 94% married) with the mean age of 45 ± 0.8 participated in the quantitative phase.

Comparison and interpretation of qualitative and quantitative results

Inappropriate situation

According to the participants' experience, one of the main categories in this study was inappropriate situation. Caregivers stated that, in many cases where the situation is not right to render information and truth to patient, they resort to the use of white lies. Inappropriate timing in the delivery of information was one of the reasons for using white lies. Participants stated that the use of white lies is temporary and if the situation and timing would be suitable, they will provide patient with genuine information. Accordingly, the category of inappropriate situation was classified into two subcategories of passing through crisis time and trying to create appropriate situation.

Passing the crisis time

The time of informing patients about an unfortunate diagnosis or the bitter truth of not telling patients that treatment will not be effective is a critical time. The participants stated that in these situations they resort to white lies to manage the crisis temporarily. One of the most critical situations experienced by the participants was the time of informing patient about an unfortunate diagnosis. Crisis management skills and competence in these situations are essential prerequisites for responding to this crisis. The son of one of the patients, who had been caring for his father with colorectal cancer for the past three years, shared his experience in using white lies when his father was informed about the diagnosis',

Table 1. Categories and subcategories based on the experiences of physicians, nurses, and patients' families

Category		Subcategory
White lies in patient care	Inappropriate situation	Passing the crisis time
		Trying to create an appropriate situation
	Patient expediency	Retention of hope
		Information refinement
	Surrounding frameworks	Accepting the differences in cultural view
		Maintaining the care hierarchy
	Communication bridges	Common language
		Common goals

"When we got out of the clinic, he sat down on the ground and said I know everything is over. I said no, the doctor told me that it is not serious and patients with this condition would be treated easily, so don't worry" (P 8).

In this regard, an oncologist with over 20 years of experience in the treatment of cancer described the use of white lies to overcome crisis,

"Consider a moment when cancer is patient's definite diagnosis for a patient who has lost her mother to cancer. When such patient asks me 'Dr. I'm going to die?' My answer is not 'yes dear, very soon'. I must say something to help patient cope with the situation, and later we can tell him/her the truth" (P 3).

Trying to create an appropriate situation

The participants in this study believed that they must first create an appropriate situation and then tell patients the truth, so until then, white lies should be used. One of the surgeons participating in the study, who had fourteen years of experience in dealing with patients' reactions (such as anger, denial, and isolation) after being informed of the truth about their diagnosis and treatment, expressed his view on the need to establish an appropriate situation before rendering information to patients,

"Sometimes telling the truth at first has the opposite effect. Patients may show a wide range of feedbacks and sometimes managing these reactions is a challenge. I ask the patients' personal information. I try to get to know them more so I can do it the right way. I usually ask the family members about what kind of relationship they have with the patients and see if they can help. We cannot be careless. If this is not done properly, we will have a patient who does not cooperate and eventually leaves his/her treatment" (P 12).

Creating the right opportunity to prepare the patient for information was a common experience mentioned by all participants. The father of an 18-year-old boy with leukemia, with regard to the lack of appropriate situation for telling the truth to his child and the need to create right situation by searching for supportive resources, stated that,

"I told everybody at home to tell him (son) he has anemia and he will soon get better by eating meat and some medicines. I said, it is not a right time to tell him and he is not yet ready. His brother is at university in another city, when he comes home, I would ask him to tell him gradually" (P 5).

According to the findings of this category, temporary white lies had been used to pass through crisis time and to create an appropriate situation. The quantitative findings of this study (presented in [table 2](#)) revealed that, all three groups of participants (patients' families, physicians, and nurses) had similar opinions about the use of white lies as a temporary solution to reduce the bitterness of unpleasant truth. All three groups of participants also gave the highest score to the use of white lies until an appropriate situation is being created. In light of these findings, creation of appropriate situation as a strategy for information rendering should be considered a priority. In this context, providing the right place for information rendering is also very important. Passing through crisis is different for different patients, but using available supports, such as a family member or friend who has a better relationship with the patient, can help to communicate the truth. Understanding patients' reactions such as anger, isolation, denial, or non-cooperation, and the ability to manage them is a necessity for both the patients' families and the treatment team.

Patient expediency

From the participants' point of view, expediency was 'to consider patient's benefit and protect him/her from potential harm caused by the bitter truth'. The participants sometimes used white lies and rendered false information to patient because they thought the patient is incapable of accepting the truth, presenting the truth may cause mental or psychological harm to patient, or the patient is not interested in knowing the bitter truth of the treatment. The main purpose of white lies in this category was to prevent hopelessness and motivate patients to follow the treatment. For this reason, the participants were altering or refining many facts and truth. The category of patient expediency had two subcategories of retention of hope and information refinement.

Table 2. Scores of the items related to the situation of using white lies (strongly agree = 5, strongly disagree= 1, sample size= 300)

No	Items related to situation	Physicians	Nurses	Patients' families
1	I use white lies to reduce the bitterness of the unpleasant truth	5	5	5
2	I use white lies in situations where the diagnosis is not good	4.4	4.2	3.2
3	I use white lies in situations where the treatment is not effective	2.1	3.2	2.3
4	I use white lies in situations of diagnosis error	1.2	1.3	3.1
5	I use white lies until the right situation is created	4.3	4.4	4.1
	Mean scores 3.3±1.2	3.4±1.4	3.6±1.2	3.5±0.78

Retention of hope

According to the participants' experiences, white lies have been used in some cases to maintain patients' hope. In the participants' view, hope maintains patients' morale and motivates them to pursue treatment and seek therapeutic goals. Conversely, patients' awareness of the imminent death or lack of response to treatment will lead to a loss of hope followed by sadness and elimination of positive therapeutic motivations. Nurses and families believed that, hope plays an important role in coping with the disease and collaborating with the treatment team. In this regard, one of the emergency room nurses with sixteen years of experience in caring for patients justified the use of white lies in maintaining hope and continuing treatment as follow,

"There have been cases, where diagnosis and prognosis have been communicated to patients with honesty and unfortunately, the result has been reversed as the patients lost hope in treatment and did not continue with the treatment" (P 16).

Sometimes in order to maintain hope, there is a need to focus on building a positive mindset. A gynecologist with over 20 years of experience referred to emphasizing positive treatment points and highlighting success rather than failure as a proved way for maintaining hope,

"The hope of a successful treatment process partly depends on the patient's informative mindset. When the patient knows that 90% of people who have gone through the same process have not gained any success, he/she will be frustrated and feel hopeless, so we need to focus on that 10% and talk about their success" (P 11).

Information refinement

Undoubtedly, the way a physician deals with the reality of his or her illness is very different from the one who has no knowledge of the disease and its treatment process, or has the experience of the same illness in the family that has led to an unfortunate outcome. In this context, it is important to consider the patient's informative capacity, acceptance, past

experiences, and level of knowledge. According to the experiences of the study participants, it is not suitable to use one method for all patients and each patient's condition and characteristics should be considered separately. One of the supervisors participating in this study with over 20 years of experience in care and management described his experience as follows,

"Patients are from different cultures with different education and experiences. Sometimes, the truth can be told to the patient in an instant, but sometimes we have to lie and filter information until the end of the illness, because the patient lacks the capacity to accept the truth. We had patients who, as soon as they became aware of the cancer diagnoses, began to seek the latest treatment, and we also had patients who fainted as soon as we told them they had gastric cancer. A single model cannot fit everyone" (P 9).

The qualitative findings of this category emphasized the need to maintain hope and refine information with regard to the characteristics of patients. According to the quantitative findings shown in [table 3](#), retention of hope was one of the reasons for telling white lies to patients from the perspective of the participants. The use of white lies has also been suggested as an incentive to treatment follow-up. The participants believed that patients did not have enough knowledge to interpret specialized information about the disease, and sometimes providing information causes anxiety and tension and disrupts patients' comfort. Moreover, considering the quantitative and qualitative findings of the study at this stage, focusing on the positive aspects of treatment and introducing those who had successful treatment can help to render true information to patients and maintain patients' hope at the same time. Paying attention to patients' individual differences in dealing with information, selecting appropriate sentences when communicating information to patients, and rendering information to patients in a proper way play an important role in reducing anxiety and stress in patients, and subsequently lead to the retention of patients' hope and motivation.

Table 3. Scores of the items related to patients (strongly agree= 5, strongly disagree= 1, sample size= 300)

No	Items related to patients	Physicians	Nurses	Patients' families
6	Patients do not have enough knowledge to understand and interpret specialized information	3.3	4.3	4.4
7	Providing information to patients creates anxiety and stress	4	4.2	5
8	Although knowing the truth is important, keeping the patients calm is a top priority	4.2	4	5
9	Patients are more inclined to hear white lies than bitter truth	3.3	4.1	4.6
10	When patients hear the truth, they lose hope for treatment	4.3	4.4	4.6
11	Patients' participation in the treatment can be invoked by white lies	3.3	4.3	5
12	Unrealistic expectations of patients result in the use of white lies	4	4.5	2.5
	Mean scores 4.1 ± 1	3.7 ± 0.65	4.2 ± 1.2	4.4 ± 1.3

Surrounding frameworks

In addition to individual characteristics, the features of patients' surroundings must also be considered when providing patients with information. One of these surrounding frameworks is culture. Not all patients are from the same cultural class. In addition, the culture of care providers and the organization is also an important factor in establishing and maintaining an effective communication channel for information rendering. The rules, frameworks, and hierarchy of the care system are also important factors in information rendering. All of these factors are surrounding frameworks that the participants referred to in relation to the use of white lies in patient care. The category of surrounding frameworks was classified into two subcategories of accepting the differences in cultural perspective and maintaining the hierarchy.

Accepting the differences in cultural view

The culture of patients, their families, and healthcare system and interaction between them are important factors in disclosing the truth to patients. Different cultures have different ways of telling the truth to patients. Awareness of such cultural differences can help in disclosing the truth to patients. One of the limitations that prevents the transfer of truth and causes the use of lies is the difference in cultural perspective. In this regard, the sister of one of the patients who needed a hysterectomy shared her experience of using white lies:

"She didn't allow us to remove her uterus. Where we live, people do not view this as a right thing to do. We convinced her to have surgery by telling white lies that they want to remove a cyst, otherwise she wouldn't have survived due to her sever bleeding" (P 21).

In this regard, one of the oncology physicians stated that healthcare culture sometimes normalizes the frank delivery of some information and diagnoses to patients that may be new to them. The cultural differences in rendering information to patients need to be acknowledged,

"We have a lot of patients coming for prognosis in this ward every day. We also have some deaths every week. We have been dissolved in the system. Some issues have become normal for us and we have taken the shape of the environment. But for patients and their families, this is a whole new game. It could be the first time they have been admitted to hospital. It is even worse when they come from deprived or rural areas and we need to be more cautious" (P 1).

Maintaining the care hierarchy

It is important to pay attention to the rules or routines available to have a uniform functioning in rendering information to patients. Although, rendering information to patients is a teamwork task, the amount of information provided to patients by care providers varies. It is up to the physician to provide further diagnostic news to patients and nurses are responsible to provide further supplementary information mainly related to the care process to patients. However, it is the responsibility of both groups (physicians and nurses) to educate the families for continuation of care. According to the participants' experiences, having no regard for this hierarchy sometimes leads to chaos and disharmony, thus, the treatment team uses white lies to compensate for this disharmony. A medical specialist with over twelve years of work experience expressed his view on the need to deliver diagnostic news to patient by physicians in the office prior to hospital admission,

"If we have prepared the patient in the office, the work will be easier. It is more difficult in the hospital to do so. Commuting and changing caregiver make it even harder. On the other hand, when nurses know that we have prepared the patient, they can do their job easier and don't have to lie to the patient or face questions about which they do not have enough information" P(20).

An emergency room nurse shared her experience about the difference between the routines and rules that different hospitals have for delivery of information to patients and lack of knowledge on these rules to maintain hierarchy,

"I've been working for ten years in two hospitals both in emergency departments. In one of them, the surgeon informs the patient about all aspects of illness and we are not involved. But here, the senior resident says something to the patient, medical student says another thing, and on-call doctor says something else. It's unclear who should give information to the patient, as a result, information given to the patient is sometimes fainter and other times bolder than the reality" (P 22).

According to the quantitative findings shown in [table 4](#) related to factors associated with the use of white lies in the care process, the participants indicated that there is no specific place in hospitals for delivery of information to patients. Furthermore, for coordination and building integrity in presenting information to patients, appropriate guidance and greater communication between the treatment team and patients' families are required.

Table 4. Scores of the items related to health care context (strongly agree= 5, strongly disagree= 1, sample size= 300)

No	Items related to health care context	Physicians	Nurses	Patients' families
13	I don't have the right place to provide information to the patient	2.1	4.2	3
14	There are no proper guidelines for information delivery	4.4	5	1.2
15	There is no proper coordination between the treatment team and the family for information delivery	4.4	4.6	5
16	Revealing the truth requires organizational culture	4.3	5	3.2
Mean scores 3.8±1.5		3.8±2.3	4.7±0.11	3.1±2.1

Accepting and respecting cultural differences in presenting the truth to patients can be a solution to this issue. Moreover, enhancing the organizational culture to adhere to the principles of providing the truth to patients will prepare a therapeutic atmosphere for the truth to be delivered to patients. In line with this culture-making, providing uniform guidelines in the hospitals for rendering information to patients is one of the requirements that specify how the information should be delivered to patients, how much information should be delivered, who should deliver the information, and what are the characteristics of right place and time for delivery of information. Emphasis should be placed on the hierarchy of information provision, division of duties in regard to what extent the information should be delivered, and reduction of inconsistency in information delivery to patients. In addition to the coordination between the treatment team members, coordination between the treatment team and patients' families is also essential in providing genuine information to patients and reducing the use of white lies.

Communication bridges

Using effective communication skills is an integral and essential part of care and creating the right communication bridges is a prerequisite for effective information delivery to patients. According to the participants' experiences, poor communication with patients can lead to problems, such as lack of access to important information, misinterpretation of information, and creation of mistrust between patients and healthcare providers. Considering patients' differences is important in establishing effective communication, one of which is the difference in the patients' languages and dialects. In addition, it is important to have a common therapeutic goal in order to put the treatment team, family, and patient on the same path and to create a bond and connection between them to achieve the common goal. The category of communication bridges contained two subcategories of common language and common goals.

Common language

Based on the findings of this study and experiences of the participants, the correct relationship goes beyond

speaking a dialect. Sometimes the patient is an elderly or a child who is not capable of interpreting information. In such cases, a common language should be established for information delivery to patients with regard to their communication ability and skills. Getting help from the family or interpreter and conducting information need assessment can be helpful. When patients and caregivers do not speak in a common language, communication is impaired, not all facts are presented to patients and caregivers resort to using white lies. In this regard, a mother whose eight-year-old child was diagnosed with Hodgkin lymphoma two years ago shared her experience,

"My kid didn't have a good relationship with the staff. He wouldn't let anyone come close to him. Well, of course, because he was too young when he was first diagnosed, we couldn't give him much information. Even that time, we had to speak in his language to help him and make him cooperate with the treatment team (eating this or that, do this or that ...). Sometimes we had to change the atmosphere and sentences, so that he wouldn't be afraid and could cooperate with us" (P 13).

Different dialects of patients and unavailability of auxiliary resources for communication were other factors that a nurse practitioner with eighteen years history of patient care and use of white lies talked about,

"We had an Arab patient who didn't understand Farsi and was illiterate. In the morning shift, a translator used to come and translate the required topics. For the night and evening shift, I had written down the translator's phone number and a series of short Arabic sentences. However, since we couldn't understand the question correctly, we usually couldn't provide the right answer, and the translator wasn't always available either. Sometimes, we had to show everything is ok to prevent him become scared and ask more questions" (P 6).

Common goals

The common goal of any care process is to improve the quality of life of the patient, and families, physicians, and nurses are working together with the patient to achieve this goal. According to the participants' experiences, in some cases, knowing

the truth does not help to achieve this goal and the use of white lies is inevitable during the treatment process. An oncologist who participated in this study commented with regard to the use of white lies in achieving the therapeutic goal,

"We say medicine, not chemotherapy. Perhaps, knowing the drug's name is not a priority for an 80-year-old woman. What we're all looking for is to start the treatment and continue it" (P 1).

Paying attention to the patients' past experiences and background information and finding the best way to communicate with them to achieve a common therapeutic goal were also mentioned by the participants. In this regard, one of the nurses working in the emergency department with ten years of experience, stated,

"The goal of everyone who comes to hospital is to get well, but not all patients are the same. The ways of achieving goals are also not the same for everyone. Knowing the patient, his/her condition, ability, and inability are all important to achieve this goal. I Myself as a nurse, the physicians, and the patients' families must be able to focus on the patient and also improve ourselves, so that we would be able to establish an appropriate communication and get to the destination. It is obvious that if this complicated issue is not well managed, it will not provide the right information, nor will it fulfill the therapeutic goal" (P 22).

According to the qualitative findings at this stage, improving the ability of information delivery to patients to achieve the therapeutic goal is one of the requirements mentioned by the participants. The qualitative findings and the data in [table 5](#), illustrating the caregivers' individual skills in providing information to patients, confirm the importance of communication skills in providing genuine information to patients. According to the findings of the quantitative phase, lack of proper and sufficient communication, lack of knowledge on ways of establishing communication, management

of personal emotions, and patients' reactions to the truth are some of the issues that interfere with proper communication and lead to the use of white lies. In this regard, using communication skills training courses, understanding patients' responses to news and adversity, and managing personal relationships are recommended to enhance communication skills. It is also advisable to use support sources and tutorials on the languages used in care process and have a guidebook and translator in all shifts to reduce the difficulty of verbal communication, especially with foreign patients. Understanding the information needs of patients of all ages to communicate properly with them and deliver accurate and commensurate information is a recommended approach according to the research findings.

Discussion

According to the findings of this study, the qualitative and quantitative results are consistent and complementary to each other. The physicians, nurses, and patients' families agreed that it is the patient's right to know the truth, but in certain situations, they have inevitably used white lies. In the present study, participants reported the use of white lies to create an appropriate situation and balance the patient's condition. Since 1979, physicians have considered several key factors in rendering true information to patients, which include patient's age, emotional stability, and intelligence (30). In the present study, participants considered patient's condition in order to create an appropriate situation for information delivery and tried to create such situation. Using white lies with the aim of passing through crisis time and reaching a right situation requires adherence to Islamic and ethical considerations. In Islamic teachings, while emphasizing the right of individuals, including the patient's right to know the truth, certain ethical considerations have also been emphasized to avoid unnecessary fear and worry in patient, especially when his/her mental state does not allow a rational decision-making (31).

Table 5. Scores of the items related to personal skills (strongly agree= 5, strongly disagree= 1, sample size= 300)

No	Items related to personal skills	Patients' families		
		Physicians	Nurses	
17	I don't have a good and adequate relationship with patients	1.3	4	4.2
18	I don't know my patients' priorities and desires	4	4.3	3.2
19	I don't know how to communicate with patients properly	4.3	2.5	4
20	I don't have the ability to handle personal emotions when I am providing information to my patients	2.3	4	4
21	I am afraid of patients' reactions to the truth.	4.1	3.9	5
22	I don't have the ability to handle my patients' unpredictable reactions	4.2	3.5	4.8
23	I am afraid of the patients' questions and not having the right answers for them	3.7	4.1	5
24	I don't know when the right time is to provide information to patients	1.3	4.3	4.6
25	I don't know how much information I should provide to patients	1.3	4.2	5
Mean scores 3.7±2		2.9±3.8	3.8±0.6	4.4±2.1

According to the participants' experiences, sometimes it is for the benefit of the patient not to know the truth as it can lead to frustration and loss of hope. Conversely, the results of the study by Seyedrasooly et al showed that disclosing the truth has no effect on patients' hope and quality of life (32), however the differences between patients should be taken into account. Moreover, considering individual patient's needs, taking sufficient time to render information, introducing more accurate diagnostic methods, possible treatments, and supportive services available when delivering information to patients can be somewhat helpful in reducing the crisis caused by exposure to the bitter truth (33). Participants believed that the capacity of patients to receive information should be considered in order to provide them with the truth. In a study on the use of lies in dementia patients, the majority of nurses reported that they considered patients' cognitive abilities for reacting to the truth (29). According to their findings, the medical staff and patients' families have been using white lies to encourage patients to participate in the treatment process. They also found that not telling the truth is for patient expediency. Of course, one must consider whether the definition of expediency is the same from the perspectives of patients and the providers of information. In jurisprudential texts, the word expediency has a vague meaning and jurists only permit lies for the expediency reason, when there is a reasonable possibility of danger and loss to one's life, property, or dignity when telling the truth. But in this case too, the treatment staff are obliged, as far as possible, to avoid making unrealistic statements and to speak the truth in straight but multifaceted terms, without attempting to deceive their clients (1).

The patient's surrounding frameworks, including cultural and organizational frameworks, were among other issues that caused the use of white lies in patient care. The obligation to tell the truth to patients varies in different cultures. The supremacy of the principle of autonomy in the Western world has made it acceptable to tell patients the truth, but in many Eastern societies, it is more common to hide the truth from patients and let the patients' families know about the truth instead, because of the family-centeredness and the principle of non-maleficence (31). A study by Kazemi et al showed that healthcare professionals never tell patients the truth about diagnosis and their decision-making differ depending on the patients' cultural and social context (34). Mahasti Jouybari et al revealed that nurses use indirect methods to provide information to patients, but do not have specific guidelines for communicating the truth to patients and their families, and each nurse has his/her own mental

behavior depending on his/her culture (35). In the present study, participants referred to the lack of proper guidelines for presenting information to patients as a barrier. In the study by Grassi et al, health care providers referred to their needs in telling the truth to patients (disease diagnosis and prognosis) and expressed that guidelines and instructions can help them to do their task properly (36).

Preparing the patients for the information they should receive through effective communication was one of the important points mentioned by the participants in this study. In fact, poor communication with patients can cause problems such as lack of access to important information, misinterpretation of information, and creation of an atmosphere of distrust between patients and healthcare providers (37). Paying attention to the right timing and place when presenting the truth to patients is also effective as most physicians recommend that, hospital is a better place to deliver information to patients than home (38). It should also be noted that patients will become aware of the truth and this should not create distrust and distance patient from the therapeutic goal.

One of the limitations of this study was that, it was restricted to hospitals affiliated to Tehran University of Medical Sciences. Further studies in other therapeutic settings can provide valuable data from other nurses, physicians, and families the findings of which can be better generalized. Moreover, this study only addressed the perspectives and experiences of patients' caregivers, and the patients' own experiences and perspectives were not investigated, which limited the more comprehensive examination of the use of white lies in the patient care process. Therefore, it is recommended to consider patients' opinions and experiences in future studies.

Conclusion

According to the findings, white lie is for the benefit of the patient and it is also used to create an appropriate situation for presenting the truth to patients. Identifying the right time, preparing the right place, and using available support sources were found to be appropriate ways to balance the situation for presenting the truth to patients. Besides, how the patients are prepared to hear the truth, how the truth is told, and how the patients' different reactions are handled are important issues to be taken into account. To tell the truth to patients, treatment team members must be familiar with the rights methods, hence, they require training to enhance their communication skills in information delivery. Telling the truth to a patient

who is mentally unprepared can sometimes not only violate his or her autonomy, but also can adversely affect his or her illness and relationship with the physician, family, or healthcare staff. In this regard, providing appropriate guidelines based on the culture and context and in line with the therapeutic goals and the patients' understanding can be used to enhance caregivers' individual skills. According to the findings of this study, different organizational cultures in different therapeutic contexts have an important impact on the way the patient is told the truth, thus, conducting further studies in different therapeutic contexts is recommended. Moreover, the present study did not examine the opinions and experiences of patients in this regard,

therefore, future studies are recommended to explore the experiences of patients in addition to the experiences of care providers.

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Conflict of Interest

There is no conflict of interest to report.

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