Muaygil *et al. BMC Medical Ethics* (2025) 26:159
https://doi.org/10.1186/s12910-025-01307-0

BMC Medical Ethics

RESEARCH Open Access

Truth-telling and devastating disclosures Navigating the tension between ethical and cultural obligations in Saudi Arabia

Ruaim A. Muaygil[1*], Noura A. Abouammoh[2], Abdossalam M. Madkhali[3], Lyan H. Almana[4] and Raniah N. Aldekhyyel[5]

Abstract

Background Truth-telling is the process by which relevant medical information is disclosed to the patient to enable them to make informed decisions about their healthcare. It serves multiple aims; first, it is essential to adequately informed consent; second, it respects patients' rights to self-determination, third, it fulfills practitioners' ethical obligations; and fourth, it promotes trust between patients and practitioners. In Saudi Arabia, research suggests that patients support truth-telling, prefer a more collaborative role in decision-making, and want to be involved in difficult decisions at the end-of-life. However, evidence also finds a disparity between the preferences of patients and their relatives, with family members favoring concealment of information to honor and protect patients. The perspectives of Saudi physicians, and the challenges they encounter when faced with these oft-contrasting preferences is not as well explored.

Methods This research is a qualitative phenomenological study that utilizes a semi-structured interview technique and interview guide. Through thematic analysis of 7 in-person interviews with senior Saudi physicians, this qualitative study attempts to understand the experiences of practitioners who routinely encounter truth-telling dilemmas, particularly in the face of strong family opposition.

Results Study participants identified family requests for concealment as significant ethical challenges in their practice. They reported experiencing moral conflict between the ethical duty of truth-telling and the cultural norms of a family-based Saudi society that favor concealment.

Conclusions Although some participants held firm in upholding the ethical duty of truth-telling, others agreed to conceal information. Most participants, however, tried to find a compromise between these contrasting commitments by relying on their own personal experiences and professional judgements.

Keywords Truth-telling, Saudi arabia, Culture, Concealment, Healthcare, Cancer

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*Correspondence:
Ruaim A. Muaygil
rmuaygil@ksu.edu.sa
[1]Department of Medical Education, College of Medicine, King Saud University, PO Box 7805, Riyadh 11472, Saudi Arabia
[2]Department of Family and Community College of Medicine, King Saud University, P.O Box 7805, Riyadh, 11472, Saudi Arabia
[3]Department of Internal Medicine, Oncology, Hematology, and Radiation Oncology Unit College of Medicine, King Saud University, P.O Box 7805, Riyadh 11472, Saudi Arabia
[4]Department of Internal Medicine, King Faisal Specialist Hospital and Research Center, Saudi ArabiaRiyadh
[5]Medical Informatics and e-learning Unit, Department of Medical Eduction, College of Medicine, King Saud University, P.O Box 7805, Riyadh 11472, Saudi Arabia

Introduction

Truth-telling in healthcare is the process by which relevant medical information- including significant, impactful information such as serious and terminal conditions, poor prognoses, potentially futile interventions, and end-of-life decisions- is communicated to patients to support informed decision-making [1]. Without truth-telling, medical information is often concealed from patients, and might result in unilateral, paternalistic decision-making by practitioners or family members [2]. Truth-telling is defended on several grounds. First, it is essential to adequately informed consent [3]. Second, it respects the rights of patients as moral agents [3]. Third, it fulfils the professional and ethical obligations of practitioners towards their patients [1]. Finally, it has a vital role in promoting trust between patients and practitioners [4].

As healthcare practice shifted from paternalistic to patient-centered care, the concept of truth-telling became increasingly essential to ethical decision-making. However, concerns about the harms of unequivocally presenting patients with the absolute truth led to moral arguments in support of concealment in certain circumstances [5]. In particular, truth-telling's Western, autonomy-focused origins were felt to be incompatible with the cultural and family-oriented practices of some societies [6].

In Saudi Arabia, physicians are often conflicted between upholding the ethical duty of truth-telling and honoring the cultural obligations that favor concealment. These complex dilemmas often result in feelings of guilt and distress as Saudi physicians are prevented from fulfilling what they consider to be their ethical obligation (truth-telling) by external pressures (patients' families, cultural norms) [7]. The perspectives of Saudi physicians, and the challenges they encounter when faced with these contrasting commitments, is not well documented. This study aims to explore and understand the perspectives of Saudi physicians as they navigate these difficult moral dilemmas in the process of truth-telling.

Background

Truth-telling in a healthcare context refers to the honest disclosure of significant medical information- including devastating diagnoses and prognoses - to patients. It is a vital component of the patient-physician relationship[8], and an essential ethical and legal obligation [1]. Truth-telling upholds the right to self-determination, supports informed consent, and enables patients to participate in shared decision making [3, 8]. It has also been found to enhance healthcare delivery through improved understanding and trust, and to provide an opportunity for goal setting and future planning [9].

The last few decades have established truth-telling as a moral imperative emblematic of the physician's ethical duty towards their patients, and the practice has become a cardinal rule of Western medicine [6]. However, some scholars have challenged unrestrained truth-telling, arguing that there are circumstances where concealment, rather than disclosure, better serves patients' interests [9]. Critics contend that there are often good moral justifications for concealment, particularly when truth-telling results in more harm than benefit [3]. This is particularly apparent in non-Western cultures where autonomy and individualism are not as culturally valued as family involvement and support [6, 10]. In these societies, concealment of devastating medical information from patients is common practice, as is the family's subsequent decision-making role [6]. Concealment in these situations is well-intentioned; it is an effort to shield vulnerable patients from distressing information and difficult decisions [6].

Saudi Arabia is one such community where decision-making is often family centered [11]. Indeed, the Saudi family plays a large role in caring for the patient, resulting in a three-way dynamic between the physician, the patient, and the family. For many Saudi families, this responsibility is considered a solemn moral obligation. It is a way of expressing love and support for their relatives, particularly when they are elderly [12]. In practice, the family is often first to receive devasting information and ultimately decides what, how, and if this information is shared with the patient[11]. It is not uncommon for Saudi families to request concealment of devastating information from patients [12–14]. Yet these requests, well-intentioned as they may be, often result in significant moral conflict for physicians who must balance their ethical obligations (truth-telling) with their cultural commitments (concealment). This conflict is additionally compounded by Saudi law which protects patients' right to receive medical information and to be involved in decision-making [15].

This study attempts to explore the perspectives of Saudi physicians who frequently encounter moral conflict in the process of truth-telling. Through an interview-based method, this work offers insight into the approaches and obstacles that permeate truth-telling and provides recommendations that may help reconcile two seemingly conflicting commitments.

Methods

This research explores the perspectives of senior physicians who frequently encounter truth-telling dilemmas at a major medical center in Saudi Arabia. It is a qualitative phenomenological study that utilizes a semi-structured interview technique and interview guide (Appendix 1). The interview guide was initially designed to address the study objectives and was continuously revised and refined based on feedback from pilot testing with two physicians and insights that emerged during early interviews. The interview guide included structured and semi-structured questions. It was designed to be locally informed, and to reflect current discourse on truth-telling obligations and culture-based arguments for concealment. Structured questions included demographic data (e.g., years of experience and specialty), while semi-structured questions attempted to understand how participants approached truth-telling dilemmas. As new themes emerged, some questions were adapted to further explore relevant areas, allowing for a deeper understanding of the phenomenon. This iterative process allowed us to capture richer, more nuanced data while maintaining consistency in exploring the central phenomenon[16].

Recruitment

Using a purposeful sampling technique, a member of the research team (AM) compiled a list of all potential participants identified as senior physicians involved in the management of cancer patients (oncologists, hematologists, and surgeons). A senior physician was defined as someone who held the title "consultant," obtained only after completing a medical residency and fellowship. Consultants are the most senior member of the medical team and are ultimately the most responsible for patient care. Participation was limited to this population for two reasons: One, senior physicians' unique authority in making disclosure decisions, and two, the high frequency of truth-telling dilemmas in the care of cancer patients [11–14]. All senior physicians on the initial list compiled by (AM) were invited via email by (RM) to participate in the interviews. The invitation included a brief explanation of the study objectives. Physicians who declined or did not respond within two weeks were removed from the list. Interviews were conducted with those who agreed to participate, and the process continued until thematic saturation was reached. Sampling and data analysis occurred simultaneously to achieve theme saturation.

Although the research team is employed by the same medical institution as the participants, none had working associations with RM or AM, ensuring personal relationships did not affect participation. Verbal and written consent was obtained before each interview.

Data collection

Interviews took place between January 2022 and June 2022 both in- person and via video conferencing platform according to each participant's preference. RM, a formally trained bioethicist, conducted the interviews with support from (NA), a research member with formal expertise in qualitative research methods. Although interviews were conducted in English for ease of transcription, participants were encouraged to speak in Arabic—their native language—anytime they preferred. Most participants chose English resulting in a limited proportion of data requiring translation. A bilingual team member (LA) transcribed the interviews. Transcripts were pseudonymized to ensure confidentiality with only RM having access to the identifier. They will remain stored in a password-protected computer hard drive for 5 years, after which they will be deleted. Similarly, all recorded interviews were encrypted and were only accessible for transcription and analysis purposes.

Data analysis

Data gathered from structured questions describing the demographics and background of participants (gender, age, years of experience, discipline, and subspecialty) were summarized using descriptive statistics. This study adopted a descriptive phenomenological approach, guided by the principles of Colaizzi (1978), to explore and capture the essence of participants' lived experiences [17]. Data were analyzed using an inductive thematic process, beginning with independent reading and code generation based on responses to semi-structured interview questions. NA and RA each independently analyzed half of the transcripts and met on three occasions to deliberate and compare initial coding. Thematic patterns were identified through iterative reading and a conscious effort to set aside preconceptions. The remaining research members reviewed the initial coding framework to ensure conceptual alignment and establish consensus. The finalized coding schema was then applied across all transcripts. To further enhance consistency and trustworthiness, two additional meetings were held between RA and RM, and NA and RM, to reconcile coding differences and reach consensus on the accurate representation of participants' experiences. From this process, emergent themes were inductively derived to reflect shared aspects of the phenomenon under investigation.

Results

Participant characteristics

A total of 17 potential participants were invited to participate. Of those contacted, five did not respond, two declined to participate, and three accepted the invitation but never scheduled an interview. Ultimately, seven participants were interviewed and are included in this study. All participants were senior physicians i.e., at the consultant level, and were aged between 35 and 60 (Table 1).

Thematic content analysis revealed three distinct themes reflective of truth-telling practices among participants: (1) drivers of disclosure, (2) the ethical conflict, and (3) response to the conflict. From these themes, 8 sub-themes emerged surrounding the experiences of participants in relation to truth-telling dilemmas. The three themes along with their sub-themes, and example quotations are summarized in (Appendix 2).

Table 1 Participant characteristics ($n=7$)

Participant	Gender	Age	Senior physician (years)	Discipline	Subspecialty
P1	M	35–41	2	Medicine	Radiation/Oncology
P2	M	41–50	11	Medicine	Oncology
P3	M	35–41	3+	Medicine	Oncology
P4	M	51–60	20	Surgery	Breast/Endocrine
P5	M	41–50	12	Surgery	Neurosurgery
P6	M	51–60	16	Medicine	Radiation/Oncology
P7	F	35–41	Less than 1 year	Medicine	Hematology

Theme 1: drivers of disclosure

Interviews uncovered the main influences impacting how participants communicate sensitive and potentially devastating medical information to their patients. All participants described their approach as honest yet careful and shared what underlies their truth-telling decisions. Under this theme, three sub-themes emerged: (1) participants' Western training, (2) cultural norms, and (3) workplace dynamics.

Participants' western training

All participants received post graduate medical training in a Western country- predominately in North America. They noted significant differences between their current truth-telling practices and their former Western-based approaches. They identified cultural, familial, and educational factors as significant influences affecting truth-telling in Saudi Arabia. One participant mentioned:

> *"Oh, my goodness! I came back [from Western training] and I couldn't believe how often it happens, because in the West if the patient does not show up, I can't write a note… I can't write a note on a patient if I don't see them… Here, the family comes, I'm like 'where is your patient?' and they say 'well she is not feeling well you can tell me, and I'll go tell her'… I can't do that, especially the conversations that are important" (P7).*

Some participants considered reconciling former training with current practice to be a significant ethical challenge.

Cultural norms

Participants believed cultural norms like religiosity and family involvement played a major role in truth-telling practices. They noted how strong religious beliefs enable the acceptance of death as Allah's will, making disclosure of devastating information easier at times. Participants similarly emphasized the family not only as an important caretaker of the patient, but as an active member of the decision-making process. As described by P4:

> *"Families are usually very supportive. They are always there, in the clinic, when the patient receives chemotherapy, when they undergo surgery. They are very supportive, truly."*

Workplace dynamics

In discussing the challenges of upholding the ethical responsibility of truth-telling, participants shared that conflicts are often heightened when the patient is a relative of a colleague. As P1 shared:

> *"I have refused referrals because the diagnosis was not disclosed and all I got was angry calls by colleagues. Some refused to refer patients to me. It's hard to be the one who wants to follow the rules if everyone else is not."*

Similarly, participants recalled being pressured by colleagues to normalize the practice of concealment, further hindering their ability to fulfil their ethical obligations. Some participants noted that the responsibility of truth-telling itself is often punted between specialists in an effort to avoid difficult conversations.

Theme 2: the ethical conflict

All participants noted significant external pressures to adapt to local practices. They shared that the burden to conform made it difficult to balance and reconcile ethical obligations with cultural commitments. Three distinct sub-themes emerged at the root of this conflict: (1) family requests for concealment, (2) professional reputation, and (3) patients' emotional well-being.

Family requests for concealment

All participants reported encountering family requests for concealment. Family members were typically the adult child of an elderly patient. Requests were often well-intentioned and rationalized as a means of protecting patients from the emotional burden of devastating medical information. Some participants struggled to fulfil these requests with one describing his experience as a "fight" with family members. As P2 shared:

> *"I had a 90-year-old patient who was illiterate and blind. His children were actually my father's age. Every time I tried to talk, they kept silencing me. At the end he told them 'shut up, I want to hear the*

> *doctor'. He was a smart guy, and the problem is we underestimate people's understanding."*

Another participant underscored the challenge of maintaining good relationships with families while supporting patients' interests. Most participants agreed that family requests for concealment were a significant cause of moral distress.

Professional reputation

Several participants believed that concern for their reputation affected their truth-telling practices at times. They noted that by upholding ethical duties they were perceived as inflexible or overly rigid, leading to a negative professional reputation. Participants expressed struggling to balance their ethical duties against the expectations and criticisms of colleagues and/or patients' families. As P1 stated:

> *"It's not easy, you end up having a reputation that you are not flexible. Things get said behind your back, that all you think about is your ego and your rulebook, that you are not willing to adapt so you know with time I think most people crumble under that pressure."*

Patients' emotional well-being

Participants believed that patients' emotional well-being is an important factor in truth-telling, with some noting that the patient's mental readiness impacts information disclosure. Several participants felt a responsibility to honestly guide patients through a difficult emotional time. Others disclosed being affected by negative outcomes, including patients' emotional reactions. As P3 shared:

> *"One of the things that really bothers me is that sometimes patients that you have a very good relationship with flip on you whenever the cancer is bad or there is disease progression. Sometimes you try to absorb this anger and try to explain to the patient that it's not the usual that it has nothing to do with me."*

Theme 3: response to the conflict

Participants described how they respond to ethical conflicts arising from truth-telling. Several mentioned that the absence of culturally informed ethical guidelines enables the adoption of various disclosure practices. To that end, participants noted that they frequently relied on their own judgment when responding to concealment requests to sometimes contrasting results. Two distinct sub-themes emerged: (1) professional judgment and adaptation, and (2) participants' recommendations.

Professional judgement and adaptation

Most participants expressed that their experiences with truth-telling dilemmas led to changes in their practice and to the adoption of wider perspectives and practices. Others, however, still struggled with navigating the complexities of balancing ethical duties with family expectations. While some participants firmly upheld the ethical duty of truth-telling, others shared that they often compromised by "not directly disclosing information" or avoiding discussions entirely and instead focusing on "hope" to align with cultural expectations. A few participants shared that in situations where they feel particularly uncomfortable or face significant ethical conflict, they might ask the patient to be seen by another physician. One participant opined that in time, one becomes more accustomed to prioritizing the patient's right to treatment, even if it means "bending the rules" to do so. According to P6:

> *"I used to be rigid about truth-telling, but I found that when I share bad results, patients become unmotivated. They may not even show up to clinic. I changed. Why should I destroy someone? The patient has likely heard it from someone else anyways, why do I need to keep repeating 'you're dying, you're dying, you're dying?' But I always tell the family the truth."*

Participant recommendations

Some participants made several recommendations to enhance truth-telling practices such as ensuring a compassionate environment or employing simplified methods like videos and online resources to aid in disclosure. They also emphasized the need for better training of healthcare professionals to enable these difficult conversations. One participant stressed the importance of engaging supportive services to assist patients receiving devastating information. Another felt that raising community awareness about patients' rights to receive information would be helpful in reducing future conflicts. According to P5:

> *"I think maybe we need public awareness, like a public health campaign. I think it will help a lot to raise the community's awareness that the patient has the right to know. Another thing that might be helpful is establishing the patient's wishes…like in an advanced directive which we don't have, but it might help families understand."*

Discussion

This study represents an attempt to better understand physician experiences with truth-telling in the context of devastating disclosures (Fig. 1). Its biggest finding, perhaps, is the perceived conflict between participants'

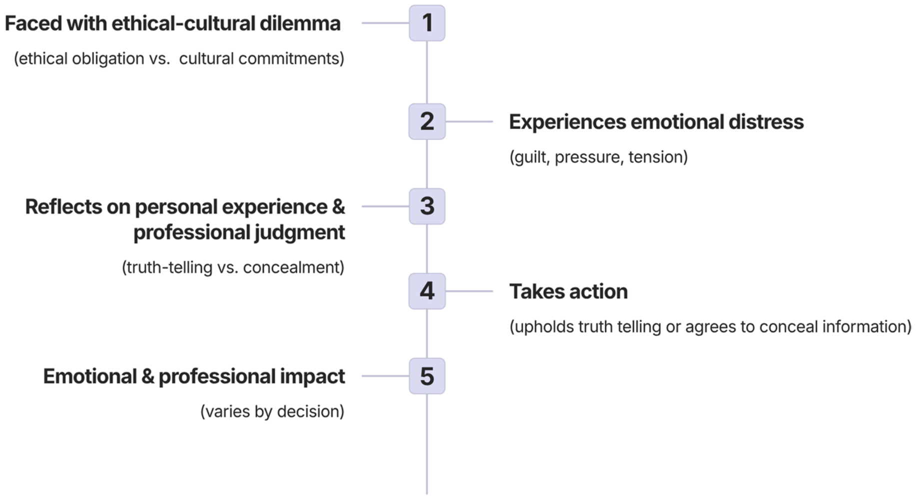

Fig. 1 Physician's decision-making in ethical-cultural dilemmas

ethical duty to disclose and the cultural norms of a traditionally communal Saudi society that favor concealment. This seeming tension was apparent in Western trained participants even if they themselves were Saudi.

Truth-telling has long been understood as a fundamental ethical duty [5]. It is essential for adequately informed consent, upholds the right to self-determination, supports shared decision-making, and strengthens the patient-physician relationship [5, 8]. Nevertheless, some scholars challenge the understanding of truth-telling as an absolute moral duty and contend that there are circumstances in which concealment may be ethically justified [3]. In particular, critics argue that truth-telling is reflective of Western values, and that non-Western countries have different understandings of what constitutes moral good [18]. Indeed, in many cultures where decision-making is primarily family-centered, relatives receive information first, and often decide whether or not to involve the patient[6, 19], as was noted in this study. In these cultures, concealment of devastating information from vulnerable patients is often motivated by compassion, love, and a duty to honor and protect the patient [18]. The preference for concealment is not limited to the family in these circumstances; many practitioners also believe truth-telling to be unnecessarily cruel, distressful, and contributing to hopelessness and poor outcomes [6, 9]. Likewise, some of this study's participants opted to conceal information when necessary, and carefully chose less threatening terminology when communicating with patients (e.g., growth instead of tumor), a practice that has been commonly utilized by practitioners elsewhere [19].

Although cultural justifications for concealment are often motivated by a desire to protect patients from the negative impact of devastating disclosures, there appears to be little evidence to support these concerns [18]. Instead, research suggests that patients who are aware of their medical conditions have fewer physical symptoms, less psychological stress, and are able to make more informed decisions [20–22]. Notably, a recent Saudi study found no significant relationship between truth-telling and the ability to cope among cancer patients [23]. Rather, much of the distress attributed to receiving devastating information has been found to be related to the manner or context in which it was communicated, e.g., through misrepresentation or accidental discovery [24–27].

Further, Saudi scholarly evidence yields interesting findings regarding truth-telling and cultural norms, identifying a disparity between the preferences of families and those of patients [28]. While some studies affirm that families often prefer concealment and desire a more central role in decision-making[14, 29], several others find that a majority of patients prefer full disclosure, reject concealment, and want to be involved in care decisions [12]. – [13, 30–32] These contrasting preferences suggest that cultural critiques of truth-telling are not always indicative of uniformly accepted practices [33]. Even within a particular culture, some norms may not be equally valued by all members [4]. Indeed, narrow understanding of cultural customs can cause significant harms, e.g., the reinforcement of stereotypes or the silencing of vulnerable populations [4]. Absent nuanced understanding and careful application, the cultural defense of concealment appears to enable partitioners and families to usurp the patient's autonomy in order to act in her best interest [33]. – [34] To that end, some Saudi scholars have argued that respect for culture should not motivate concealment, nor preclude patients from participating in decision-making [11, 35].

Still, concealment remains an accepted, and important, moral practice in many cultures [18]. When aligned with the patient's informed and voluntary preferences, concealment can respect and promote cultural values, while also fulfilling the practitioner's ethical obligations [18]. When the patient's preferences are unknown, however, ethical justifications of concealment are not as readily apparent, and it is not unusual for practitioners to struggle between ethical and cultural commitments. In these circumstances, practitioners who conceal information from patients often feel guilty and responsible [36]. This emotional burden was similarly reported by all participants, with some describing moral distress- knowing the morally correct response but being prevented action by external pressures- [37] when faced with family requests for concealment.

Participants differed in how they responded to the perceived conflict between ethical and cultural obligations. Some held firm in upholding the ethical duty of truth-telling while others agreed to conceal information. Most participants tried to find a compromise between both commitments. Participants who concealed information from patients seemingly rationalized their decisions through therapeutic privilege, i.e., withholding information when there is reasonable expectation that disclosure will result in serious physical or mental harm [38]. Therapeutic privilege has been defended on the grounds that it prevents psychological distress, preserves hope, and maintains long-term autonomy [5]. Still, scholars caution against unrestrained application of therapeutic privilege, and restrict its utilization to limited circumstances [5]. Critics remain skeptical of its alleged promotion of patient welfare and contend that harms like the denial of autonomy and exclusion from decision-making result in more harms than benefits to the patient [39].

Participants who tried to fulfil both ethical and cultural obligations noted their responsibility towards both the patient and the family. They viewed the family as a care partner and underscored the significance of family bonds and social relationships in the Saudi community. Family is often a source of strength and hope to patients[6], and in Saudi Arabia can be seen as an extension of the patient themselves [11]. It is not unusual then, to consider that respect for the Saudi patient's autonomy may very well include an account of their relational autonomy. As identified by feminist scholars, relational autonomy emphasizes social context and relationships and suggests that individuals make decisions in line with these interactions [40]. In order to respect someone as an autonomous individual, these relational bonds and their influence must also be recognized [41]. Therefore, the inclusion of the family- with the patient's consent- may be an effective method of fully respecting their autonomy, and honoring both ethical and cultural obligations.

The addition of the family as an active partner invites an interesting parallel to pediatric decision-making where three parties- the patient, the provider, and the family (parents)- are also involved in healthcare decisions, all of whom with unique perspectives and preferences [42]. – [43] There are two obvious distinctions from pediatrics where the parent- the third party- is the ultimate decision-maker; one, the patient remains the decision-maker with the family- the third party- in a supportive role, and two, the family is only included with the patient's consent. Family involvement through this triadic decision-making model has been also advocated elsewhere in adult medicine, most notably in the care of people living with dementia where it offered important insights into patient preferences and values regarding decision-making [44]. – [45].

It is salient to reiterate that the family's involvement should only be permitted with the consent of the adult patient with decision-making capacity regardless of cultural norms [35]. Practitioners must always attempt to elicit patient preferences regarding truth-telling and decision-making, including what role-if any- they want their family to play. "Offering truth" as proposed by Benjamin Freedman is a widely utilized ethical approach of determining what each patient knows, wants to know, and to which extent they want to be involved in decision-making, before disclosing any information [46]. This approach respects the patient's autonomy and their right to self-determination, while also being cognizant of the importance of cultural values.

Strengths and limitations

The strengths of this study lie in its novel examination of a fraught ethical dilemma. Although the perspectives and preferences of patients and their families regarding truth-telling have been documented in Saudi literature, the disclosure practices of physicians are not as well understood. The study's identification of not only the moral challenges, but the approaches by which Saudi physicians navigate these complex situations render this work a notable scholarly contribution.

The study's population represents an interesting limitation. All participants were senior physicians as they were the ones authorized with making disclosure decisions, however, it is likely that junior members of the team, as well as non-physician healthcare workers encounter similar truth-telling conflicts. Understanding the experiences of other healthcare workers is essential, particularly as their ability to disclose may be limited by their professional role. Similarly, the inclusion of only one woman participant may have impacted the study's findings. Saudi women physicians constitute a minority in the country, and it is doubtless that their experiences and perspectives are uniquely affected by both their limited representation and by overarching cultural dynamics.

Additionally, the study's restriction to one medical center, and the relatively small sample size, may impact the generalizability of its findings. Likewise, because all participants are Western trained, their experiences may differ greatly from those who have received training elsewhere. Follow-up studies are needed to understand the experiences of more diverse physician and patient populations, various regional contexts, and in different healthcare settings.

Conclusion

This study represents an attempt to better understand Saudi physicians' experiences with truth-telling in the context of devastating disclosures. Participants identified family requests for concealment as significant challenges in their practice. They reported experiencing moral conflict between the ethical duty of truth-telling and the cultural norms of a traditionally communal Saudi society that favor concealment. Although some participants held firm in upholding the ethical duty of truth-telling, others agreed to conceal information. Most participants, however, tried to find a compromise between these contrasting commitments by relying on their own personal experiences and professional judgements.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12910-025-01307-0.

Supplementary Material 1

Supplementary Material 2

Acknowledgements
The authors would like to thank all the participants for their thoughtful, passionate, and courageous insights. The authors would also like to thank Ongoing Research Funding Program, (ORFFT-2025-093-1), King Saud University, Riyadh, Saudi Arabia for financial support.

Authors' contributions

All authors contributed to the study conception and design. Material preparation and data collection and analysis were performed by RM, NA, AM, LM, and RA. Sections of the manuscript's first draft were divided among, and written by, all authors. The final version was written and edited by RM and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Funding
Ongoing research funding program (ORF-2025), King Saud University, Riyadh, Saudi Arabia.

Data availability

De-identified transcripts and interview guides are available upon request from the corresponding author.

Declarations

Ethics approval and consent to participate

Ethical approval was granted from the IRB at King Saud University number E-21-5816. Informed and voluntary consent was obtained prior to the conduction of each interview. Participants consented to being interviewed, audio recorded, and to the use of their statements and experiences in this work without identification. Participants understood they could withdraw at any time. This study adhered to the Declaration of Helsinki guidelines.

Consent for publication

Not Applicable.

Competing interests

The authors declare no competing interests.

Received: 25 February 2025 / Accepted: 22 September 2025

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