Original Article

White lies in pediatric care: a qualitative study from nurses' perspective

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Abstract

Communication and sharing information with ill children are challenging. To protect a child from the bitter reality, sometimes use of well-intended untruths, or white lies is necessary. This research aimed at studying the experiences of nurses about the use of white lies in in pediatric clinical setting.

In this qualitative, content-analysis study, 24 on-duty pediatric nurses were interviewed in 2019. Data were collected through purposeful sampling using semi-structured interviews, and the collected data were analyzed according to Granheim and Landman's method using MAXQDA-10 software.

Eighteen female and six male nurses with the mean age of 42 ± 3/7 years and mean work experience of 16 ± 4/1 years were selected to participate in this study. Data analysis showed that use of white lies depends on both situation and several other factors classified into five general categories: nature of data, childhood characteristics, family norms, treatment team's capabilities and organization policies.

Treatment team members need to improve their communication skills to convey therapeutic information to the ill child's family appropriately. To do so, special guidelines should be prepared for healthcare staff in pediatric clinical setting.

Keywords: Ethics; Pediatrics; Truth-telling; Content analysis.

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Introduction

Implementation of therapeutic measures for children can be an undesirable experience for parents and caregivers (1). Statistical data show that three percent of the children have been hospitalized at least once during their childhood, and nearly five percent of them have been admitted to the therapeutic centers for treatment (2). Due to clinical differences between children and adults, special skills are required in pediatric care (3). The importance of pediatric nurses' vital role is becoming more prominent, and hence the significance of educating pediatric caregivers and clinical practitioners about promoting child health is becoming more highlighted in order to provide child care at the highest standard (4).

In pediatric setting, caring for children involves effective communication with children and their families to deliver high-quality care during hospital stay or even after discharge (2). Communication methods are influenced by various factors such as child's age, parents' needs and cultural norms (5). Some parents oppose or resist the disclosure of bad news to protect their child, which is common in Asian culture (6, 7). Review of literature and research on this topic in Iran, Pakistan, Israel, Jordan, Lebanon, Palestine, Turkey, United Arab Emirates and Saudi Arabia showed that viewpoints of Middle Eastern regarding disclose of truth is different and varied (8).

In Middle Eastern culture, concealing truth is considered protection against the bitter truth, and hence medical and care staff are forced to disclose bad news in distorted, indirect, changed ways, typically called white lies (9, 10).

A white lie can be considered an ethical decision made in certain circumstances (e.g., facing a bitter truth) to protect the patient from predictable harm without personal motivation or self-interest. (11). James et al. (2006) in their research showed that white lie can be seen in all levels and 96.4% of clinicians use it as a communication strategy (12). Deciding on the following options is an ethical challenge requiring knowledge of ethical principles, disclose truth, conceal truth, or use white lie (13). Nurses should have an understanding of ethical reasoning to preserve their patients' rights without compromising their own moral conscience (14). Otherwise, in complicated clinical situation, wrong decisions followed by inappropriate interventions may result in undesirable consequences for the patients, their families, or even the nurses.

According to the researchers' experience in nursing care and other available studies, white lies are frequently used in children care process (5, 15). Since nurses' perceptions and experiences are formed through continuous encounters with real world situations, studying their state of mind, feelings, emotions, as well as their experiences leading to white lies in childcare domain is extremely important. To do so, the qualitative study method was an appropriate research methodology capable of searching through such states and experiences. To the best of our knowledge, no qualitative study has been conducted on the use of white lies in children care so far, and hence this study

was the first to review nurses' experiences of white lie in pediatric care setting.

Methods

This qualitative study with content analysis approach was designed and conducted in 2019. In this study, purposeful sampling was used to select the samples from on-duty nurses working in pediatric medical, surgical, critical and emergency wards of four teaching hospitals affiliated to Tehran University of Medical Sciences. The criteria for entering the study include the followings: at least a bachelor's degree in nursing, willingness and consent to participate, at least one year of work experience in pediatric ward, and capability of expressing personal experiences regarding the study's subject. Nurses with managerial position or with no experience in childcare were excluded from this study.

Data were collected using semi-structured one-to-one interviews scheduled at participants' preferred time and location. Each interview lasted between 45 to 60 minutes. Data analysis was performed based on conventional content analysis approach suggested by Granheim and Lundman (16). Initial interview questions included the followings: Have you ever experienced a situation where you did not want to tell the truth or could not tell the truth to your patient? Under what circumstances, did you use a white lie during patient care? Then, depending on the dynamics of the interview, more detailed questions were asked to gain a deeper understanding of the participants' experiences.

After carefully listening to the recorded interviews, they transcribed verbatim. After reviewing the transcripts and mentorship's notes, the words, sentences and paragraphs were considered as the conceptual units, which later were assigned specific codes. Data management was done using MAXQDA software version 2010. The codes were compared to find similarities and differences, and then classified into several categories. Data validity and reliability were assessed using Guba and Lincoln method (17). Credibility of the data was assured using two methods: (*i*) checking the collected data by members and peers having prolonged engagement with the related topics, and (*ii*) considering maximum variation during sampling with cases purposefully as different from each other as possible. Transferability of the findings was attained by rich descriptive data collection and analysis to allow readers match findings with their context. In addition, detailed and descriptive data analysis as well as use of experts' experiences were utilized to achieve dependability. Conformability and consistency of the analysis were confirmed through discussions among the research team members and resolving disagreements.

This research was conducted under the supervision of Ethical Committee of Tehran University of Medical Sciences with IR.TUMS.VCR.REC.1397.568 code of ethics. All participants were asked to sign written consent forms after being informed about the study's objectives and method. Confidentiality of the data was maintained, and the possibility of early withdrawal was provided to the participants.

Results

In this study, 24 nurses with the mean age of 42±3/7 years and the mean work experience of 16±4/1 years were participated. All participants were married and had no managerial or executive position. They were exclusively caring for children under the age of 12 (Table 1).

Table 1- Participants' characteristics

Characteristics		Number
Gender	Female	18
	Male	6
Education Level	Bachelor's degree	13
	Master's degree	5
	Doctoral degree	3
Ward	Medical/Surgical (M/S)	11
	Operating Room(OR)	2
	Intensive Care Unit (ICU)	4
	Emergency Department (ED)	4

Data analysis on 454 initial codes showed that the use of white lies depends on situation. The initial codes were classified into five main categories: nature of data, childhood characteristics, family norms, treatment team's capabilities, and organization policies. Shown in table 2, each main category had several sub-categories.

Table 2- Categories & sub-categories

Categories	Subcategories
Nature of data	Bad news
	Technical data
Childhood characteristics	Fear and insecurity
	Continues questioning
Family norms	Culture
	Child protection
	Decision-making responsibility
Treatment team's capabilities	Respect of values
	Ethical reasoning
	Communication skills
Organization's policies	Organization's principles
	Organization's instructions

Nature of data

Technical terms in medical news are difficult to understand even for adults. However, participants believed that patients should receive comprehensive information that is concise and appropriate to their level

of understanding and literacy. Otherwise, if information cannot be conveyed in this way, use of harmless or white lies become inevitable. Therefore, nature of medical data was defined as one of the main categories of this study that led to the use of white lie in pediatric care setting. This category had two subcategories: bad news and technical data.

Bad News

Based on the participants' experiences, families and caregivers tend to hide unpleasant news and facts. Instead, they tend to convey more appropriate and hopeful news out of compassion, and white lies can make difficult situations such as delivering bad news easier. A participant stated, "*Children are too young to be told that they have an incurable and dangerous illness unlikely to be healed. Telling the bitter truth is not possible. Such news is even difficult for adults and they cannot accept it*." [Participant No. 6].

Technical Data

Conveying technical information (e.g., diagnostic tests, treatments, medications, and care), especially in incurable diseases, to children is difficult if not impossible. Nevertheless, informing children is essential to attracting their cooperation and participation in the care process. A post Intensive Care Unit (ICU) nurse with 14 years of work experience stated, "*It is not possible to talk to the child using technical terms. Even if we could explain medical information in a very simple language, not all information would be transferable. We have to simplify or change the information, so sometimes we need to use lie*." [Participant No. 9]

Childhood Characteristics

The aim of informing patients is to respect patients' autonomy, to gain their trust to participate in care and treatment process, and to allow them to have complete awareness of the situation to make informed decisions. Due to various factors such as children's age, their inability to do self-care, and their lack of legal responsibility for decision-making, healthcare staff sometimes are reluctant to deliver all correct clinical information to patients. The children's ability to interpret and use such information is different from that of adults due to their childhood characteristics, which can become an obstacle in disclosing truth. This category had two sub-categories: (*i*) fear and insecurity, and (*ii*) continuous questioning.

Fear and Insecurity

Answering children's continuous questioning and coping with their fear, insecurity and restlessness, when isolated from their families or caregivers, are among the reasons for the use of white lies. A participant said, *"Parents are not allowed to accompany their children to the ICU. When children want to see their parents, we tell them that their parents are waiting behind the ICU door, and if you allow us to inject the medicine or if you are a well-behaved child, we let them into the room to visit you. But, in fact, at that time, parents are often not in the hospital."* [Participant No. 11]

Continuous Questioning

According to the participants, the caregivers' fear and frustration over children's constant questioning forced them to use white lies. One participant stated, *"We tell the child that he will have surgery. He begins to ask about the type of surgery. In response, we say, for example, that you will have abdominal surgery. The child then asks where the abdomen is located and where in the abdomen will be operated on. We answer, for example, that the stomach will be operated on. Then the child asks what is the stomach and where it is located. Can't I eat chocolate if you operate on my stomach? Can I go to school without a stomach? May I die of surgery? Did the patient next to my bed who had died recently had a stomach and did he die because of it? These questions go on and on. "[*Participant No. 20]

Family Norms

Despite different cultures, all families seek to support and protect their children. In addition, the legal decision-maker for the children is usually their guardian or one of their parents. This category had three sub-categories: culture, child protection, and decision-making responsibility.

Culture

According to the participants, in some cultures, families do not disclose the illness or eminent death to their children, and hence at the request of the family, the medical team are forced to use white lies. An on-duty nurse in children surgical ward with six years of work experience shared her findings," *She was a little girl and had problems with her perineal region. Her parents did not want to tell her anything about the disease and asked us to tell her that she was going to have a tummy operation. They did not allow us to use specific terms related to this region."* [Participant No. 12]

Child Protection

Parents use white lies to protect their children against bad news and ask the treatment team to do the same. A participant said, *"The parents thought that if she knew, she would be very upset. Her younger sister died of the same disease last year, so she should never know that she was suffering from the same disease."* [Participant No. 1]

Decision-Making Responsibility

Although respecting patient autonomy is a principle of ethical care, children are less involved in decision making related to their care process. Intricate parents-child communication as well as ill child's dependence, fragility, and immature decision-making capability make the parents the final decision-makers in care process. A participant stated, *"The parents sign all consent forms and make decisions in all situations. They ask us not to tell the children what is happening so that they do it themselves. When the children ask us, we do not tell them the truth because their parents have asked us not to do so."* [Participant No. 3]

Treatment Team's Capabilities

Treatment team members' various opinions and outlooks on the appropriateness of different methods as well as their lack or absence of basic skills are among the reasons for using white lies. Acquiring necessary skills or enhancing them promotes

treatment team's capabilities in children care according to medical ethics principles. Treatment team's capabilities had three subcategories: (*i*) respect of values, (*ii*) ethical reasoning, and (*iii*) communication skills.

Respect of Values

In children's care process, the participants have experienced situations where they have decided to conceal the truth and use white lies based on their personal values. An on-duty nurse in pediatric oncology ward with 10 years of work experience stated," *My nephew suffered from cancer, and we did not tell him until his death. We knew that he would die, but we liked to see him happy. Now, I do not tell my patients that they have cancer, or at least I do not want to be the person telling them what is going on."* [Participant No. 15]

Ethical Reasoning

According to participants, the ability of ethical reasoning to evaluate different angles of truth-telling can help caregivers decide whether to use white lies or not. A participant stated, *"I look at the situation and sometimes it is impossible to tell the truth. Telling the truth in inappropriate situations may frustrate and frighten sick children, which may eventually stop them from cooperating. We have to wait for the right time."* [Participant No. 18]

Communication Skills

Communication is a fundamental concept in nursing care. The following skills are required in pediatric care: (*i*) understand child's feeling, (*ii*) assess the need to disclose some or all of the information, (*iii*) effectively communicate with the child in a friendly way, (*iv*) provide information to the children according to their level of understanding, and (*v*) realize suitability of time and place to communicate with the child. Absence or lack of the above-mentioned skills may force the caregivers to use white lies. A participant said, *"Working with children is difficult. You should know how much they know, what they know, what experiences they had, how much they know about death at this age, and what information their parents has given them. You also need to reassure them because they may be afraid of the treatment team. You need to make them feel safe and speak to them in a language they can understand, and be prepared to respond appropriately to their requests and questions."* [Participant No. 9]

Organization's Policies

As a health care organization, hospitals pursue their goals of providing the most appropriate care with the best quality; however, they focus more on medical care and less on other aspects of care (e.g., availability of information to the patients, especially the children). Integrity of the organization's principles in valuing all healthcare and medical aspects as well as developing guidelines in line with these principles can facilitate delivering information to children. The organization's policies category had two subcategories: organization's principles and organization's instructions.

Organization's Principles

If the organization provides the principles of telling the truth to children in a comprehensive guidebook accessible to all staff, the treatment team can use that guide in delivering information to patients, thereby minimizing inconsistencies and resolving conflicts. Without providing such guidebook for all on-duty caregivers, they employ their personal and preferred approaches where white lies can be part of them. A participant said, *"To fulfill patient's rights, precise and true information should be presented to the patients. However, if their physicians, their supervisors, or their families oppose, what should we do? If I follow the rules, then who will answer these opponents?"* [Participant No. 2]

Organization's Instructions

According to the participants, instructions for truth disclosure to patient is more adult-oriented, and no clear set of instructions exists for the children. An on-duty nurse with 14 years of work experience in pediatric operating room stated, *"Recently, to break bad news to adults, some instructions have been provided, which are not so practical. For children, however, no instructions have been prepared. A set of instructions would be very useful for the children since they are completely different from adults."* [Participant No. 17]

Discussion

The research aimed to study nurses' experiences regarding the use of white lies in pediatric care setting. The findings of this study were summarized into five main categories: nature of data, childhood characteristics, family norms, treatment team's capabilities, and organization's policies. Nature of data is a common reason for the use of white lies as breaking bad news or delivering highly technical information to children is challenging. Although disclosing bad news to children is frustrating, the way the news is presented can help alleviate stress (18-20). Disclosure of information should be done gradually, systematically, in smaller sections with proper control and management. Family and the ill child should be involved in the care process with full support of treatment team, even if they are not eager to hear all the information. Furthermore, childhood characteristics are also among the reasons for filtering information and using white lies (18, 21). Children's age and their needs should be considered in information disclosure. Kelly et al. stated that adolescents tend to receive filtered information from their family (22). Information disclosure causes confusion and fear among children in some instances. Healthcare staff frequently perform the duty of disclosing information to the families. After information disclosure, answering ill child's continuous questions are challenging. According to the participants, white lies were used to manage such questions or to conceal information to keep ill child happy without answering numerous sad questions; Our findings are in line with those of Sadat-Hoseini and Aramesh (23). Nevertheless, children should be kept informed on what is happening around them, because if they attribute their pain and sadness to various wrong causes (e.g., punishment of God, not being a well-behaved child), the

circumstances would be intolerable to them. To cope with such circumstances, families should help relieve distress and anxiety of their children (24).

Various parents has their own parenting styles (25), and these styles are affected by different factors (e.g., culture, ethnicity, language, gender and socioeconomic status). Hence, when interacting with healthcare team, such styles affect the interpretation of clinical data, decision making and treatment process (26). According to our findings, since parents' contribution in child's care is inevitable, healthcare team, especially the nurses, should understand their cultural differences, and their cultural sensitivity should be considered in interactions. Parents to protect their ill child ask the healthcare team to filter information or even use white lies (27). However, intentional truth concealment even benevolently can have negative consequences. Parents are their children's decision-makers, so they cannot make informed decision about their child's treatment if being deprived from information of diagnosis, treatment process, and prognosis. Additionally, without such information, parents may have unrealistic requests during treatment process or follow therapeutic measures that are futile, unreasonable, useless and unprotective (28, 29). Parents with realistic perspective of ill child's condition experience less regret after making a decision (5). The use of white lies in pediatric care also depends on the abilities of the treatment team to communicate. Competent treatment team with effective communication skills can mutually cooperate with parents and facilitate information disclosure to the ill child. According to Valizadeh and Ghasemi, although nurses seem to have a positive attitude towards parents' involvement in caring for sick children, in practice, nurses' attitude is negative or neutral, especially in emergency cases or in implementation of specialized procedures (30). Furthermore, to comply with the rules and ethical principles, nurses should not only know their personal values, but also respect patients' values. Nurses are caring for patients with cultural varieties and are obliged to provide comfortable clinical environment for their patients (31). Therefore, they should effectively communicate with their multicultural patients to reach a mutual understanding. Nurses in their professional activities and duties should consider patients' values and beliefs, and they should be able to deliver healthcare services to patients irrespective of their cultural background. Lack of knowledge and cultural competence cause the nurses to care for the patients without considering their culture and religious beliefs (32).

Healthcare organization's policies about use of white lies in clinical setting can facilitate disclosing information to children; however, no definite organizational protocol, guide, or instruction set has been provided. According to Culley et al., no formal instructions have been provided to disclose or conceal the truth; no precise or technical definition for white lie has been presented; when to use while lie and how to use white lie have no clear guidelines (33). In line with our findings, Jouybari et al. stated that nurses use indirect methods for disclosing

information and no special instructions have been provided on how to tell the truth about treatment to patients and their families. For information disclosure, different nurses have their own ways derived from several factors (e.g., values, beliefs, mindset, and cultural context) (34). In Grassi et al. study, healthcare staff highlighted their need for guidelines and instructions to disclose disease-related information (i.e. diagnosis and prognosis) (35).

This study was based on the experiences of pediatric nurses regarding white lies. Further qualitative studies on this subject with other approaches and situations are recommended. In addition, further comprehensive investigations on corrective measures in different educational, social, and organizational settings can elaborate nursing promotions in ethical care and methods of information disclosure to children.

Conclusion

Regarding children's expediency, social structure and culture together with customs and traditions may prioritize the principle of "no harm" over "individual discretion" and "justice" in information disclosure to children. However, in defining child's best interests, or expediency, real sources of children's harm should be realized and distinguished from illusionary sources. Enhancing healthcare team's skills in information disclosure and communication as well as providing special guidelines for information disclosure are requirements for truth-telling to children to preserve their fundamental rights. As an ethical principle, disclosure of information to children should be performed considering their special needs and level of understanding with the least possible harm.

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Conflict of Interests

All authors declare no significant competing interests that might have influenced the performance or presentation of the work described in this article.

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