Alberta Doctors' Digest

Cultural differences in diagnosis disclosure

In Canadian health care, we often assume that delivering a diagnosis is a straightforward process – one in which patients have the right to know, and physicians have the duty to inform. Yet, in practice, how and when we communicate a diagnosis varies significantly across different patient populations. Without realizing it, we apply different standards depending on age, cognitive ability, and cultural background, often without asking patients how they prefer to receive medical information.

Influence of patient age in diagnosis disclosure

Let’s think about pediatric patients. In hospitals, children are frequently left out of discussions about their own health. While parents or guardians are briefed in detail, children are often not directly told why they are there, even when they are capable of understanding and may do better with more information. Contrast this with adult patients, who are routinely given their diagnoses immediately, without being asked whether they want full disclosure. Ironically, many older adults – especially those with cognitive decline or complex conditions – might actually prefer not to know, deferring decision-making to their loved ones. However, they are rarely given the choice to opt out of receiving difficult news.

Cultural differences in diagnosis disclosure

Beyond age, cultural perspectives further challenge our assumptions. In some cultures, disclosing a serious illness to a patient is seen as distressing, even harmful. In Bengali culture, for instance, it is often believed that acknowledging illness can accelerate its progression. Families may request that a diagnosis be shared with them rather than the patient, reflecting deeply held cultural values around care and protection.

However, in a western medical system that prioritizes patient autonomy and informed consent, these cultural practices can create ethical dilemmas for physicians. A well-intentioned doctor may feel obligated to disclose a diagnosis directly to the patient, despite the family’s wishes. This can lead to distrust between health care providers and families, particularly if the physician appears to disregard cultural sensitivities.

These examples reveal an uncomfortable truth: in Canada, we do not have a universal approach to delivering diagnoses. Instead, we rely on assumptions – about what patients want to know, what they can handle and what is best for them – without always considering their personal or cultural preferences. As we strive for more patient-centered care, we must move beyond these default approaches and create space for nuanced, individualized conversations.

How can we ensure that every patient is informed in a way that aligns with their values, needs and wishes? The answer starts with recognizing and challenging our own assumptions.

For medical students, this means developing not only clinical expertise but also cultural humility and communication skills. How we disclose a diagnosis is not just a medical decision – it's a human one. By actively engaging with patients and their families, we can ensure that our approach to delivering difficult news is both compassionate and ethical.

The role of medical education

To better prepare future physicians, medical education should incorporate training on flexible, patient-centered communication strategies. This includes:

1. Teaching students to recognize and challenge their own assumptions. Encouraging self-reflection on biases related to age, culture and cognition.
2. Providing case-based learning on diverse patient scenarios. Exposing students to real-world complexities in diagnosis disclosure.
3. Encouraging shared decision-making conversations early in medical training. Teaching students how to navigate discussions where patient preferences may differ from standard disclosure practices.

What's done at the University of Alberta

Both authors of this article are second-year medical students at the U of A. Our medical curriculum actively addresses these challenges through discovery learning (DL) sessions, which occur every Monday, Wednesday and Friday in our preclerkship years.

These carefully developed small-group, case-based discussions guide us through the entire patient journey – from their initial presentation to diagnosis, treatment and potential complications – under the supervision of an experienced physician. The goal is not to stereotype or make assumptions about a patient's background, but rather to develop culturally competent approaches to care.

Some cases we've encountered include a middle-aged caucasian man with substance use disorder, a middle eastern man with heart valve disease, and a young child presenting with a limp, each requiring tailored communication and clinical considerations. Importantly, we do not learn about cultural perspectives in isolation. When cultural factors are relevant, they are addressed in consultation with individuals from those communities to ensure accurate representation.

Additionally, throughout all four years, we participate in structured communication sessions, where groups of four students take turns in simulated clinical encounters – sometimes playing the role of the physician, sometimes the patient. For example, we have practiced addressing a child appropriately based on their developmental stage by role-playing pediatric visits where one student acts as a child coming in with a concerned parent. We've also worked with simulated patients presenting with sexual dysfunction, learning to navigate sensitive topics and ensure patient comfort. Another valuable experience was a small-group discussion with an LGBTQ+ individual, where we directly heard about their challenges in the health care system, emphasizing the importance of patient-centered, individualized care.

These training opportunities help us recognize our own biases, challenge assumptions, and develop flexible, empathetic communication skills. These are all essential qualities for any future physician.

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