BAD NEWS THROUGH THE FAMILY: HOW UZBEK DOCTORS ROUTE SERIOUS DIAGNOSES OF OLDER PATIENTS

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Abstract. Protocols for breaking bad news, such as SPIKES, are built around a conversation with the patient, while studies from the Middle East, Turkey and East Asia report that families often learn of a serious diagnosis first. This study describes how Uzbek doctors deliver serious diagnoses of older patients. Data from one Uzbek city include a survey of 99 doctors, a survey of 22 patients and relatives, telephone interviews and informant accounts, and field notes from 21 routine consultations. Of the doctors, 89% (95% CI 83–95%) reported first telling a relative and 2% the patient. In 12 of 14 older-patient cases the diagnosis was told with a relative involved, while seven of eight patients aged 30–59 were told alone ($p = .001$). Six linguistic tactics of routing bad news are described, together with euphemism and the anxiety that protective routing can cause. The findings rest mainly on self-report.

Keywords: breaking bad news; family-first disclosure; euphemism; older patients; SPIKES; Uzbek medical discourse

1. Introduction

The best-known protocol for breaking bad news, SPIKES, guides the doctor through a conversation with the patient: setting up the interview, assessing the patient's perception, finding out how much the patient wants to know, giving knowledge, responding to emotions and closing with a strategy (Baile et al., 2000). Involving family members is not a separate step. Cross-cultural research describes other practices. In Saudi Arabia, doctors and, still more often, patients preferred telling the family first about incurable cancer (Mobeireek et al., 2008); in Middle Eastern publications doctors often inform a family member first (Bou Khalil, 2013); and in Turkey most relatives of cancer patients did not want the diagnosis disclosed (Ozdogan et al., 2004).

Post-Soviet settings add a further layer. Soviet medicine prohibited telling patients a cancer diagnosis, and Russian legislation of 1993 obliged doctors to inform patients about diagnosis and prognosis (Kogoniya et al., 2016, pp. 265–266). Russian medical-education writing now presents SPIKES as the most developed model and treats telling a young adult patient's father first as an error (Markova & Barsukova, 2022, pp. 137–139). Uzbek law gives citizens the right to information about their own health (O'zbekiston Respublikasi, 1996, art. 25). Who is told about a serious diagnosis, and in what words, therefore involves a cultural norm, a legal norm and everyday communicative practice that may pull in different directions.

As far as could be established, the language of this practice in Uzbek medicine has not been described. This article asks how often Uzbek doctors report telling a relative first, how the patient side describes disclosure, which linguistic tactics are used to route bad news, where such routing reaches its limits, and how doctors' reports relate to what was observed.

2. Data and methods

All material comes from one city in Uzbekistan and was gathered in October 2026. Because no serious diagnosis was disclosed during fieldwork, reported data carry most of the weight here. An online

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survey of 99 doctors (clinical residents and teaching staff of clinical departments; 89 under 35 and 89% women) contained ten closed questions, one of which asked to whom the doctor usually first tells an older patient's serious diagnosis: the patient, a relative, or both together. Its answer options were drawn from pilot interviews. A parallel survey of 22 patients and relatives (13 relatives of older patients, one patient over 60 and eight patients aged 30–59) asked to whom the diagnosis had been told, without specifying severity. Relatives answered for most older patients, so their answers are treated as informative on facts and as the relative's own view on evaluations.

Qualitative material comprised 16 telephone interviews held on 29–30 October 2026 with four doctors (S-1 to S-4), four older patients (K-1 to K-4), four relatives (Q1 to Q4) and four patients aged 30–40 (O1 to O4), noted down after each call, and seven consultations reconstructed by informants (Kuzatuv 1–7). Two pairs (K-2 and Q2, K-4 and Q4) describe one consultation from both sides. These sources were not used in any calculation. Field notes from 21 observed routine consultations, nine with patients aged 60–65, served as a check on reported practice. Proportions are given with 95% confidence intervals and group differences were tested with Fisher's exact test. The study was approved by [ethics committee name, protocol number and date]; participation was voluntary and no names or diagnoses were recorded.

3. Results

3.1 What the two surveys show

Of the 99 doctors, 89% (95% CI 83–95%) said that they usually first tell an older patient's serious diagnosis to a relative, and only 2% said they tell the patient. The patient-side survey gives a related picture, with the caveat that its item did not specify severity. In 12 of the 14 older-patient cases the diagnosis was told with a relative involved, in seven cases to both patient and relative and in five to the relative only. Among the eight patients aged 30–59 the diagnosis was told to the patient alone in seven cases ($p = .001$).

3.2 How doctors explain their choice

In the telephone interviews three of the four doctors said that they tell a serious diagnosis to the family first, and justified this as protection:

(1) Ruhiyat buzilsa, immuniteti tushib ketadi.

'If the patient's state of mind is upset, their immunity drops.' (S-1)

(2) Yoshi o'tgandan keyin og'ir gap aytish noto'g'ri.

'Once a person is old, it is wrong to tell them hard news.' (S-3)

S-1 added that relatives know the patient's psychology well. The fourth doctor, S-4, tells the patient first and turns to relatives only if the patient panics or the patient's blood pressure rises. Patients' and relatives' accounts agree with the majority view: in several episodes a son or daughter-in-law was told and the patient received a softened version.

3.3 Six tactics of routing bad news

Six tactics were identified in the interviews and informant accounts (Table 1).

Table 1. Tactics of routing bad news

Tactic	Content	Example	Source
Telling separately	The relative is called out, or the patient is sent out	The doctor beckoned the daughter-in-law outside; the father was sent out and the son told	K-2, Q2; Q1

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Tactic	Content	Example	Source
Two versions	A softened version for the patient, full information for the relative	Menga yengil tushuntirdi 'He explained it to me lightly'	K-2; S-4
Announcing the change of channel	The doctor says in the patient's presence that the rest will go to a relative	Qolganini akangizga tushuntiraman 'I will explain the rest to your brother'	Kuzatuv 7
Making the relative the messenger	The news reaches the patient through the relative	Singlim, eringizga ayting, baribir olinadi 'Sister, tell your husband, it will have to come out anyway'	O1
Transferring the right to decide	Consent to treatment is given by the relative	The son consented to the operation	K-4, Q4
Choosing by the patient's state	The patient is told first, a relative if the patient panics	The doctor's own account	S-4

The first two tactics separate the audiences in space or in content. K-2 and Q2 describe the same visit: the 65-year-old patient remembered a "light" explanation, and her daughter-in-law remembered being beckoned outside. The third and fourth tactics make the change of channel audible to the patient, and the fifth moves the decision itself. The sixth sets a limit to family-first disclosure, since S-4 bases the choice on the patient's psychological and physical state.

3.4 Euphemism

Softening sometimes becomes euphemism, as in Hech narsa emas, shunchaki sal yog' bosgan jigar 'It's nothing, just a slightly fatty liver' (S-4), Qoningiz sal kamayibdi 'Your blood count has dropped a little' (Kuzatuv 7) and Milkingizni sal ochib qo'yamiz 'We'll just open your gum a little' (O4). The common markers are the diminishing adverb sal 'a little' and the limiting particle shunchaki 'just'. Patients often accepted this. A patient whose dentist had used a euphemism said meni aldadi, lekin yaxshilikka 'she deceived me, but for my own good' (O4). In K-4 and Q4 a 70-year-old patient who had not agreed to an operation reportedly had it carried out under the pretext of an examination, with his son's consent, and later commented Jiddiylik bemorga yomon ta'sir qiladi 'Seriousness has a bad effect on a patient'. Such a case is the most extreme form of family-first practice and conflicts with the patient's right to informed consent.

3.5 When protection fails

In Kuzatuv 7 a 32-year-old woman was told that the rest would be explained to her brother. She later wrote that this sentence, together with the doctor's worried look, made her more anxious: the doctor smiled and spoke calmly, lekin ko'zlari sotib qo'ydi 'but her eyes gave her away'. When verbal reassurance and nonverbal cues diverge, the announcement meant to spare the patient can signal that something is being withheld. The patient here was younger, so the case shows a possible cost without showing how often it arises with older patients.

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3.6 Declared and observed practice

In the nine observed routine consultations with older patients, the news was told to the patient every time, so the share told to a relative first was 0%, against the 89% reported. The two figures do not contradict each other, since the survey asked about serious diagnoses and the observed visits were routine. They cannot be compared directly either, and the claim that serious news about older patients passes through the family rests on self-report and retrospective accounts.

4. Discussion

The 89% figure places the surveyed doctors among the groups that most often report family-first disclosure. In Mobeireek et al. (2008), telling the family first was preferred by 48% of Saudi doctors and 65% of patients, and comparative data cited there give 80% for Japanese and 6% for US doctors. Bou Khalil (2013) links the Middle Eastern pattern to the stigma of cancer, lack of training in breaking bad news and absent regulation of informed consent. Ozdogan et al. (2004) found that 66% of Turkish relatives opposed disclosure, more so when they knew little about cancer, and Zahedi (2011) argues that truth-telling must take account of the values of patients and families in each culture. The comparison needs caution: question wording differs, the Saudi and Japanese data concern incurable cancer, and the Uzbek sample consists mostly of young women doctors in one city. The Uzbek pattern also recalls the Soviet practice of withholding cancer diagnoses (Kogoniya et al., 2016).

Most of these studies measure attitudes about who should be told. The six tactics add a description of how family-first disclosure is carried out in speech: the doctor divides the audience or the content, announces the change of channel, delegates the telling or the decision, or makes all of this depend on the patient's state. Between full telling and silence there is thus a graded set of options. Where Markova and Barsukova (2022, p. 139) see an error in telling a father before an adult patient, the Uzbek doctors interviewed describe the same act as protection. Since Uzbek law gives the patient the right to information, the gap lies between a legal norm and practice as well as between cultures, and recommendations such as SPIKES cannot be transferred without taking it into account. The approach of S-4 suggests one way to combine the two norms. In such settings the SPIKES step of finding out how much information the patient wants might also ask whom the patient wants involved, a possibility that would need testing.

The main limitation is that no disclosure of a serious diagnosis was observed. The doctors' survey reflects mostly young doctors, the patient-side survey is small, relies on proxy answers and did not distinguish serious from routine diagnoses, and the pilot material was reconstructed from memory.

5. Conclusion

Most surveyed Uzbek doctors reported that they first tell a relative about an older patient's serious diagnosis, and the patient-side survey and pilot accounts are consistent with this. The interviews and accounts show six tactics for routing bad news, from telling separately to choosing according to the patient's state, and euphemisms marked by sal and shunchaki. Patients often accepted softening, but one account shows that a visible change of channel can increase anxiety. Observation of real disclosure conversations and patients' own evaluations of them are needed to test these findings.

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