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Original Article

From Paternalism to Shared Decision Making: A Qualitative Phenomenological Study of Physician–Patient Communication Styles in Pediatric Hematology/Oncology within the Iranian Cultural Context

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Abstract

Objective: Effective physician–patient communication varies across cultural contexts, ranging from paternalistic to collaborative models. In pediatric hematology/oncology, family-centered interactions are crucial due to children's developmental limitations and cultural expectations. Given the paucity of research in this area, this study aimed to explore the diverse communication styles adopted by pediatric hematologists/oncologists in Iran.

Materials & Methods: A phenomenological approach was employed to capture physicians' lived experiences. Data were collected through 10 in-depth semi-structured interviews with pediatric hematology/oncology specialists. Analysis followed Van Manen's six-step framework, ensuring systematic interpretation of meaning. To enhance rigor and transparency, the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines were applied throughout the process.

Results: From 2,881 initial codes, 7 themes and 26 subthemes were identified. Communication styles emerged as a fluid spectrum including: paternalistic style (reflecting cultural expectations of authority), defensive style (minimizing legal responsibility), role-based style (emphasizing therapeutic duties and emotional distancing), informative style (transparent reporting and realism), shared decision-making style (often rendered superficial due to cultural constraints), hedonistic style (prioritizing patient satisfaction), and empathic-emotional style (emphasizing deep emotional connection).

Conclusion: Communication styles varied according to patient cognition, cultural beliefs, physician experience, and perceived legal risks. A key finding was the importance of preference match between physicians and families, as alignment produced the highest therapeutic satisfaction. No single model fits all contexts, underscoring the need for structured training that equips physicians to adaptively shift between styles while maintaining resilience in family-centered care.

Keywords:
Physician-Patient Relations
Decision Making, Shared
Medical Oncology
Qualitative Research
Health Communication

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1. INTRODUCTION

The physician-patient relationship, founded on mutual trust and the inherent vulnerability of the patient, represents one of the most profound human interactions within healthcare [1]. Ethically, this relationship constitutes a covenant grounded in mutual consent, wherein the physician pledges to uphold patient autonomy, confidentiality, and the highest standards of care [2]. This dynamic exists along a spectrum defined by the degree of patient participation, ranging from a paternalistic model to a collaborative partnership [3].

A seminal framework for analyzing this continuum was proposed by Emanuel and Emanuel, who delineated four distinct models: (1) the paternalistic model, where the physician determines the best course of action; (2) the informative model, where the physician acts as a technical expert providing facts; (3) the interpretive model, where the physician helps clarify patient values; and (4) the deliberative model, characterized by shared moral deliberation about health-related values. This typology remains a cornerstone for examining the ethics and dynamics of clinical decision-making [4].

However, the applicability of these models is neither universal nor static; it is profoundly mediated by cultural norms and clinical context [5]. In Western, individualistic societies, communication often prioritizes patient autonomy and collaborative decision-making. Conversely, in many collectivistic and Islamic societies, hierarchical relationships, paternalistic or family-oriented decision-making, and indirect communication may prevail, reflecting dimensions such as high-power distance [6-8].

The clinical context introduces another layer of complexity, particularly in pediatric hematology-oncology. Chronic and life-threatening illnesses impose distinct psychological burdens. Pediatric patients, with their developing cognitive capacities, often struggle to comprehend abstract concepts like mortality and long-term treatment, leading to significant anxiety [9]. Consequently, the family-centered care model has become the cornerstone of this field. In this model, parents serve as primary advocates, caregivers, and interpreters of medical information, making effective communication with the family—rather than solely with the child—a critical component of care [10].

What fundamentally distinguishes this study is its focus on the precise intersection of three critical dimensions: the clinically sensitive field of pediatric hematology-oncology, the culturally specific context of Iran, and the complex communicative dynamics inherent in family-centered care. While each of these areas has been investigated independently, their convergence creates a distinct set of challenges that remains largely unexplored. This triple intersection—where life-threatening childhood illness meets collectivistic family structures within Iran's unique socio-cultural fabric—generates communication dynamics that cannot be adequately understood through existing Western-derived frameworks. Specifically, what remains absent from the literature is a systematic, physician-derived account of the range of communication styles employed within this intersection—as opposed to isolated documentation of discrete ethical or communicative difficulties. The paucity of research examining this specific convergence constitutes the primary gap that the present study seeks to address.

Evidence from the Iranian context reveals multifaceted discrepancies substantiating this gap. Regional studies indicate that physicians face substantial ethical and communicative challenges when interacting with parents of children with hematologic and oncologic malignancies [11]; however, this prior work centered on discrete ethical dilemmas rather than on mapping the broader spectrum of communication styles physicians themselves adopt, which is the focus of the present study. Furthermore, a lack of structured communication frameworks contributes to inconsistencies in family support and decision-making, especially within palliative care [12]. Research on childhood cancer survivors and their parents has also documented persistent expectations for improved communication, noting that the dominance of a medical-only approach creates substantial obstacles throughout the cancer journey [13].

The imperative for culturally adapted frameworks is further reinforced by emerging Iranian research. Studies demonstrate that family functioning significantly correlates with quality of life in children with cancer, profoundly affecting parents' social, physical, and psychological well-being [14]. Concurrently, family-centered empowerment models have shown measurable positive effects on outcomes such as life expectancy in children with cancer [15], while barriers to effective practice have been documented at multiple levels—from interpersonal communication to cultural, social, and organizational dimensions [16]. These findings collectively indicate that Western-derived communication models cannot adequately accommodate the distinctive interplay of family dynamics, cultural values, and clinical challenges characterizing pediatric hematology-oncology care in Iran.

To address this gap, the present study employs a Qualitative Phenomenological Approach. Its primary objective is to conduct an in-depth exploration of the lived experiences of pediatric hematology-oncology specialists in Iran regarding their communication and interactions with the families of

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their patients. By focusing on the physicians' perspectives, the study aims to elucidate the prevalent communication patterns, behavioral styles, perceived challenges, and contextual factors that characterize these clinical encounters. Accordingly, this study seeks to answer the following research question: what are the range and characteristics of communication styles that pediatric hematology-oncology physicians in Iran adopt in their interactions with patients' families, and what cultural, clinical, and legal factors shape their use? The ultimate goal is to utilize these insights to inform the development of culturally adapted, standardized communication guidelines. Such guidelines are intended to better support clinicians in their practice and, indirectly, enhance care outcomes for children with chronic hematologic and oncologic diseases in Iran.

2. METHODS

2.1. Research Design and Methodological Framework

This study employed a qualitative phenomenological methodology to conduct an in-depth investigation of the communication styles between pediatric hematologists/oncologists and families of children affected by hematologic and oncologic disorders. The research delineates the core characteristics of these styles and examines the challenges associated with their application within Iranian culture. Moreover, it forms part of a larger project exploring the lived experiences of these physicians, undertaken with the aim of developing a culturally grounded communication protocol.

2.2. Participant Selection and Eligibility Criteria

In line with established qualitative research procedures, purposive sampling was employed to recruit pediatric hematologists/oncologists in Iran. Ten subspecialist physicians with more than 15 years of professional experience were included. All participants were faculty members at Iranian medical universities and had documented practice across 16 provinces of the country; moreover, three of them were still actively working in provinces outside Tehran at the time of data collection. This ensured broad contextual and experiential diversity within the sample.

To maximize the variance of lived experiences and strengthen the depth of data, the purposive selection process was coordinated with two senior faculty members (one full professor and one associate professor) in pediatric hematology/oncology. Both had over 20 years of professional experience and served on the executive boards of the Iranian Society of Pediatric Hematology and Oncology and the Iranian Society of Thrombosis and Hemostasis. Their extensive professional networks and long-standing collaborations enabled them to identify and validate eligible colleagues, thereby ensuring maximum coverage of diverse perspectives.

Eligibility criteria required participants to hold subspecialty certification in pediatric hematology/oncology, have more than 15 years of professional experience, maintain active faculty status at Iranian medical universities, and demonstrate work experience in public hospitals in Iran. Confirmation of eligibility was obtained through coordination with the two senior faculty members. Physicians who did not meet these criteria were naturally excluded from the process.

2.3. Data Collection Procedures

The data collection for this qualitative phenomenological study was conducted between February 2023 and June 2024. In-depth, semi-structured, face-to-face interviews served as the primary method of data generation. All interviews were carried out by a team of three psychologists: two female clinical psychology master's graduates and one male doctoral candidate in health psychology, each trained in qualitative interviewing techniques.

Given the cultural sensitivities and the importance of fostering trust and emotional openness, the research team carefully considered the characteristics of each participant when assigning interviewers. In particular, the gender and academic background of the interviewer were strategically selected to maximize participants' emotional disclosure and the richness of the information shared. This culturally responsive approach ensured that participants felt comfortable and respected throughout the process.

Interview sessions ranged from 50 to 170 minutes, with an average duration of approximately 70 minutes. The extended time frame allowed for deep exploration of participants' lived experiences, consistent with the phenomenological emphasis on capturing the essence of meaning-making.

2.4. Pilot and Main Interviews

The initial three interviews were treated as pilot sessions to refine the interview protocol and ensure preparedness for the main study. These pilot interviews allowed the research team to adjust question phrasing, sequencing, and interviewer strategies to better align with the study's objectives. The remaining seven interviews comprised the

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core dataset for analysis. Each of these sessions lasted between 40 and 95 minutes, with an average duration of approximately 55 minutes.

2.5. Interview Protocol

Interview questions were developed in accordance with Creswell's phenomenological framework [17]. The structure of the interviews began with a broad, open-ended question designed to elicit participants' general perspectives. This was followed by exploratory "what" and "how" inquiries that probed deeper into the lived experience. Each interview concluded with a more confrontational prompt, encouraging participants to reflect critically on their experiences. For each thematic domain, one or two principal questions were posed, supplemented by follow-up probes to ensure depth and clarity.

2.6. Sample Size Justification and Theoretical Saturation

According to established qualitative research literature, participant numbers typically range from 5 to 25 individuals, with theoretical saturation generally guiding the endpoint of data collection. It is commonly advised to conduct an additional 3 to 4 interviews beyond the point of saturation to ensure comprehensive coverage of experiential variance. In the present study, saturation was reached following the seventh interview, given the substantial volume and richness of the data obtained. Nevertheless, to more thoroughly capture the diversity of participant experiences and with the consensus of the entire research team—including clinical psychologists and a hematology-oncology subspecialist—data collection was extended to include 10 interviews.

In addition to qualitative agreement, empirical validation supported the saturation point. Specifically, analysis of the 10 interviews yielded 557 distinct codes, organized into 26 subcategories and 7 overarching categories, all demonstrating substantial reproducibility. These findings reflect a robust frequency and breadth of thematic coverage, affirming the adequacy of the sample size in representing the full range of participant experiences.

2.7. Analytical Framework and Rigor Strategies

For the analysis and coding of data, the research team employed van Manen's six-step framework for phenomenological inquiry within the health domain [18, 19] (**Figure 1**), which facilitated a nuanced, contextually grounded, and semantically rich interpretation of the physicians' lived experiences.

Step 1. Immersion in the Phenomenon

The researchers engaged deeply with the phenomenon by immersing themselves in the physicians' professional environment. With the formal approval and authorization of the hospital administration, the team was granted access to the hematology and oncology ward of Mofid Children's Hospital in Tehran. They spent extended periods in the clinical setting, observing treatment procedures, communication exchanges between physicians and families, and the broader psychosocial atmosphere of the ward. Direct presence alongside the physicians during their daily rounds and therapeutic interventions allowed the researchers to witness firsthand the complexities of pediatric hematology/oncology practice. This immersion was complemented by consultations with senior medical staff and systematic review of relevant literature, ensuring a comprehensive orientation toward the phenomenon.

Step 2. Exploration of Lived Experience

The lived experience was explored through 10 semi-structured, in-depth interviews with pediatric hematology/oncology subspecialists. Interviews were conducted in hospital offices or designated quiet spaces within the clinical environment, ensuring confidentiality while maintaining proximity to the physicians' professional context. Beyond verbal data, the researchers observed physicians' interactions with families, their navigation of treatment protocols, and the organizational dynamics of the hospital setting. These observations, made possible through hospital permission and the physicians' cooperation, enriched the dataset by situating interview narratives within the lived realities of clinical practice. Sustained collaboration with hospital staff further ensured objectivity and contextual fidelity.

Step 3. Hermeneutic Reflection and Thematic Analysis

Hermeneutic reflection was carried out through thematic analysis, which included repeated listening to audio recordings, multiple transcript reviews, and both individual and group coding sessions. The process unfolded in three stages: open coding, selective coding, and final categorization, with sentence-by-sentence coding performed collaboratively and themes refined through iterative review.

Step 4. Orientation to the Phenomenon

The team maintained a clear and consistent orientation to the phenomenon by aligning emergent codes with research objectives after each interview, conducting additional observations or interviews as needed, and consulting regularly with clinical staff and senior faculty members in pediatric hematology/oncology.

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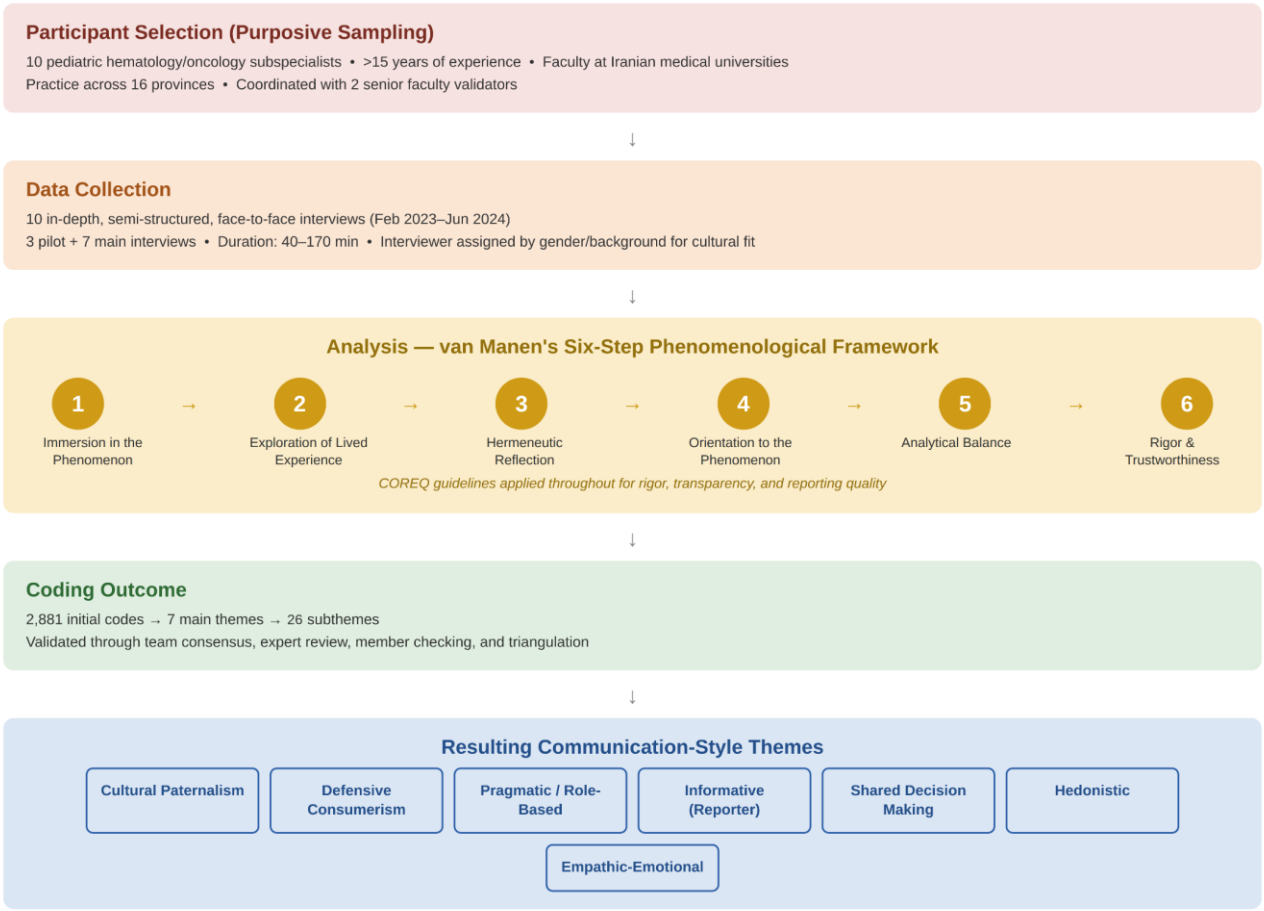

Figure 1. Study Design and Analytical Framework. Overview of the qualitative phenomenological process, from purposive participant selection through van Manen's six-step analytical framework to the identification of the seven communication-style themes and their subthemes.

Step 5. Analytical Balance

Analytical balance was ensured by continuously shifting between granular data, initial codes, and overarching themes to preserve both detail and holistic insight.

Step 6. Rigor and Trustworthiness

To reinforce the rigor and trustworthiness of the findings, the study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ). The final analysis was validated through team consensus, expert review by psychologists and clinicians, and member checking with selected physicians. Additional strategies—including triangulation, literature comparison, and re-evaluation of codes by three methodological and content experts—were employed to enhance validity, coherence, and reliability of the results, in accordance with van Manen's principles and COREQ guidelines [19, 20].

2.8. Ethical Considerations

Throughout all phases of the study—before, during, and following data collection—the principal investigator adhered strictly to professional ethical standards, guided by the ethical codes established by the American Psychological Association as well as national regulations governing medical research in Iran. Informed consent was obtained from all participating pediatric hematology/oncology subspecialists, and their rights were fully respected at every stage. Each physician received a clear explanation of the study's objectives, was assured of confidentiality through anonymization of transcripts and reports, and was granted the option to withdraw any statements after the interview. Participants also retained the right to decline answering specific questions and to discontinue their involvement in the research process at any time without consequence. All procedures were conducted with hospital authorization and in compliance with institutional ethical review requirements, thereby ensuring that the study-maintained

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integrity, transparency, and respect for the professional and personal boundaries of the physicians involved.

The principal investigator also confirmed the absence of any conflict of interest and guaranteed that all interview questions and procedural steps were faithfully aligned with those outlined in the approved research proposal. Ethical approval for the study was obtained from the School of Public Health at Zahedan University of Medical Sciences, under the ethics code IR.ZAUMS.REC.1401.1402. The study was conducted as part of a joint contract and collaborative project with the Head of Ali Asghar Children's Hospital in Zahedan and the Head of the Children's Congenital Hematologic Disorders Research Center at Mofid Children's Hospital in Tehran. These institutional collaborations ensured that the study was firmly grounded in both regional and national research priorities, while maintaining rigorous ethical oversight.

3. RESULTS

Following phenomenological analysis of in-depth interviews with pediatric hematology/oncology specialists, 2,881 initial codes were condensed into 7 main themes and 26 subthemes (**Figure 2**). The findings revealed a dynamic spectrum of communication styles adopted by physicians in clinical encounters. The most frequently recurring and salient themes identified included: paternalistic style, defensive style, role-based style, informative style, shared decision-making style, hedonistic style, and empathic-emotional style. Each style exhibited distinct characteristics and underlying subthemes, which are presented in detail below.

3.1. Theme 1: Cultural Guardianship/Paternalism

The paternalistic or guardian model refers to a clinical relationship in which the physician, based on professional knowledge, expertise, and clinical competence, independently determines the diagnostic and therapeutic trajectory, as well as the timing of initiation and termination of interventions, while the patient is primarily encouraged to comply with these decisions without being granted autonomy in decision-making. The preference for and acceptance of this relational model by both healthcare providers and patients are highly contingent upon cultural context and sociocultural conditions. In traditional societies, this model demonstrates greater legitimacy and acceptance; notably, the relationship in such contexts is not strictly unidirectional but is frequently reinforced and, in some cases, explicitly demanded by patients themselves [21].

3.1.1. Authoritativeness to Ensure Treatment Adherence

Several physicians reported that their firm, even directive, behavior is a cultural response to the implicit or explicit demands of the patients themselves. From the patients' perspective, a strong and decisive recommendation is interpreted as an indicator of disease severity and the necessity of therapeutic intervention. Consequently, authoritative physician behavior functions as a mechanism for enhancing treatment adherence.

For instance, Physician No. 1 described his experience as follows:

"My primary concerns regarding patients often stem from their cooperation... People sometimes explicitly want this type of approach; they even say, 'You didn't tell us firmly enough!'... It's as if you should have 'hit me on the head' to make me go and do this. "

This statement indicates that "authoritativeness" in this context has transformed into a communication strategy in which both the physician and the patient play a role in its construction.

3.1.2. Legal-Cultural Barriers to the Ethical Duty of Guardianship

There are circumstances in which patient autonomy may need to be overridden and clinical action undertaken based on the principle of beneficence within the therapeutic relationship. Such intervention is typically warranted when the patient or their legal guardian lacks decision-making capacity despite the presence of serious risk and potential harm. Under these conditions, from the physician's perceptual standpoint, paternalistic action is at times construed as a professional and moral obligation. When obstacles impede the fulfillment of this obligation, physicians may experience significant psychological distress and feelings of helplessness. These barriers may also be cultural and social in nature. In accordance with Iran's sociocultural context and, in particular, the legal support afforded to the legal guardian (most commonly the father), this issue was exemplified in the experience of Physician No. 2, as described below:

"During my fellowship, I encountered a case involving a father from a remote area whose teenage daughter, around 13 or 14, was diagnosed with leukemia. We intended to initiate treatment, and when the side effects of chemotherapy were explained, they asked whether her hair would fall out. We said yes. The girl had very long hair. The father initially gave consent, but later took the child away and said he would not allow the treatment if her hair was going to fall out. No matter how much we explained that her life was in danger and that her hair would grow back, he refused. Ultimately,

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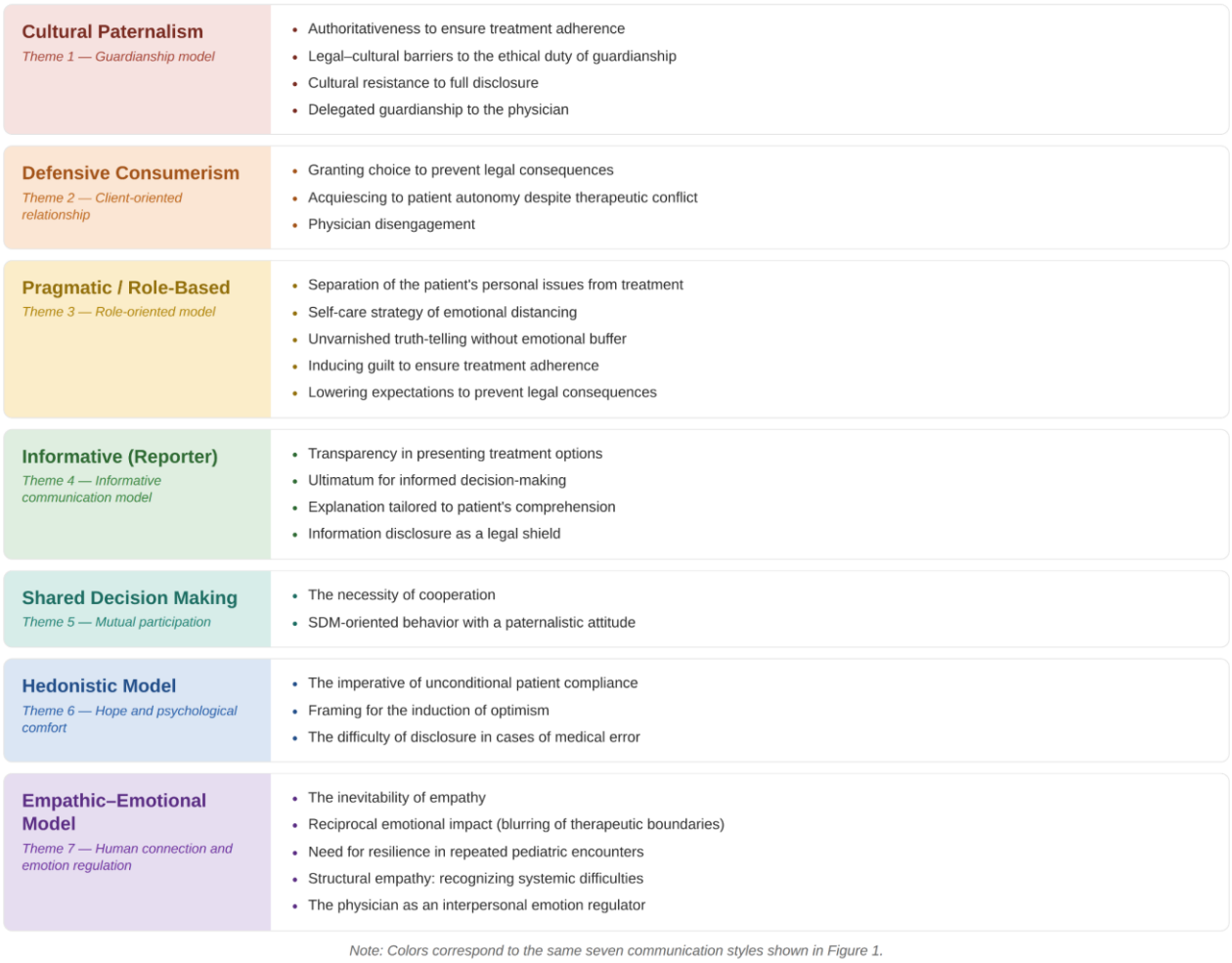

Figure 2. Themes and Subthemes at a Glance. Summary of all seven communication-style themes with their constituent subthemes, allowing the core findings of the study to be grasped at a glance without reading the full Results section.

we did not know what to do. We could not be accused of acting unprofessionally for proceeding without consent, and yet we could not do anything further either. There was no legal authority we could contact–if we called the police, they would simply say: he is her father and has the right [to decide]."

3.1.3. Cultural Resistance to Full Disclosure

Based on the findings of the present study, the perspectives of several Iranian physicians who participated in the interviews indicate that absolute transparency and the full delegation of decision-making authority to the patient are regarded as approaches that are incongruent with Iran's medical culture. From the viewpoint of this group, such guidelines are primarily derived from Western standards and international organizations, without sufficient consideration of the cultural characteristics and expectations of Iranian society. In contrast, they view the physician's "guardian role" and an emphasis on "repeated hope-giving" as methods aligned with the cultural disposition of Iranian patients. For example, Physician No. 3 emphasized that the preferred approach in interactions with patients is not the blunt disclosure of the prognosis, but rather supportive accompaniment combined with gradual disclosure of information. Physician No. 3 articulated this perspective as follows:

"I am not at all in favor of blunt disclosure. Not at all! This bluntness with the patient is a Western culture; as far as I have researched, it is not part of religious directives either. It is not right to tell a patient right at the beginning that 'you will die in a month' or 'you have a ten percent chance in three months.' You must explain a phenomenon to the patient gradually, prepare them, and this is very important, and always speak to them hopefully. So, I am not saying facts should not be told to the patient; facts should be told, but to the extent that it does not push that patient to a stage of torment, distress, and doubt."

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This perspective frames "guardianship" not as an imposition, but as a supportive action in harmony with cultural values.

3.1.4. Delegated Guardianship to the Physician

The findings of this study indicate that some physicians adopt a critical stance toward the shared decision-making model and the guidelines derived from it, regarding such frameworks as constructs rooted in Western culture. From the perspective of these physicians, within the Iranian cultural context, societal expectations require them to assume the role of "benevolent guardians" who make decisions on behalf of the patient and implement them accordingly. Moreover, they believe that the attribution of this "guardianship" by the family to the physician does not represent an imposed obligation, but rather a form of active and voluntary delegation of responsibility. For instance, Physician No. 3 described this issue as follows:

"Yes, this happens quite often. Sometimes textbooks state that you should leave the decision to the family, but in our culture, families tell us: why are you placing this decision on our shoulders? You should decide. This is very common in Iran; our culture is very different from that of Western societies. This is where we say that sometimes patients cannot make decisions themselves and come to us so that we can decide for them."

This finding demonstrates that, in many cases, the guardian model constitutes a form of culturally negotiated agreement between the physician and the patient/family, rather than merely a coercive action imposed by the physician.

3.2. Theme 2: Defensive Consumer-Oriented Relationship

Within this communication pattern, the physician–patient relationship comes to resemble a service transaction. The physician assumes the role of a "service provider" and transfers full decision-making authority and ultimate responsibility to the "consumer" (the patient). Although this model ostensibly emphasizes respect for patient autonomy, in practice it is often shaped by precautionary motives and functions as a means of self-protection against potential consequences.

3.2.1. Granting Choice to Prevent Legal Consequences

The findings of this study indicate that, in some cases, physicians attempt—while formally retaining their professional responsibility—to transfer the ultimate responsibility for outcomes to the patient. Although this granting of choice appears, on the surface, to reflect respect for patient autonomy, at a deeper level it is driven by precaution and serves as a defensive shield against potential legal and judicial repercussions. For example, Physician No. 4 described this issue as follows:

"At least you show that you did everything you could... I say, 'You can decide; I will do it. But if you think it's better somewhere else, you can go! It's up to you!"

This statement indicates that the delegation of decision-making is primarily intended to demonstrate the absence of professional negligence, rather than to facilitate genuine shared decision-making.

3.2.2. Acquiescing to Patient Autonomy Despite Therapeutic Conflict

In some instances, physicians completely refrain from asserting their professional judgment and accept the patient's choice—even when that choice is detrimental to the patient's health. This phenomenon is clearly reflected in the statement of Physician No. 5:

"I said, 'Do whatever you want, take [the child] home...' I have done everything that could be done... I can't force you. There is no compulsion. If you stay, I'll be happy... If you go, I'll also be happy that you left."

3.2.3. Physician Disengagement

The findings of this study indicate that, in some clinical encounters, physicians, after being exposed to abusive behavior, illegal and hazardous requests (such as demands for the prescription of medications prohibited in Iran), or recurrent conflicts, decide to restrict or terminate the therapeutic relationship to protect themselves from diverse potential consequences. Nevertheless, they continue to provide emergency care to preserve the patient's life. For example, Physician No. 6 described this situation as follows:

"Look, the patient came in, behaved very poorly, made an illegal demand–' You must prescribe this foreign drug; I know what should be written'–shouting and causing a scene. Ultimately, it reached a point where I wrote, 'Whenever this child has an emergency problem, I am available. But for elective conditions and routine decision-making, I will no longer see this patient. You can complain to whomever you wish.' He was one of those people who said, 'Are you writing this?' I said, 'Yes, I am writing it.' I wrote in writing, 'In an emergency, I will save you; if the child's life is in danger, I will act. But I will no longer manage your elective treatment. You do not have the right to come for preventative care or such.' It had an impact; it was over."

3.3. Theme 3: The Pragmatic / Role-Oriented Model

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This communication pattern, aligned with Parsons' theory termed the functional or role-based model, defines the physician's role as that of a technical specialist. Their primary and non-negotiable priority is solely to advance the treatment protocol, where the physician acts as an effective, non-affective agent. Consequently, both parties in the interaction are protected by an emotional distance. In this model, the patient's emotional, psychological, and familial issues are relegated to a secondary priority unless they directly disrupt the treatment process. This orientation, which is rooted in realism, emotional burden management, and, at times, self-protection against environmental pressures, manifests in various forms in physician–patient interactions [22].

3.3.1. Separation of the Patient's Personal Issues from the Treatment Process

From this perspective, treatment is regarded as an independent and specialized trajectory that should not be interrupted by the patient's everyday life crises. The physician considers it their professional duty to proceed with treatment even when the patient is experiencing significant personal hardship. Physician No. 4 clearly articulated this stance as follows:

"For example, I see the child's parents are getting divorced. I cannot say, 'It's okay, we'll pause your treatment until you are psychologically ready!' I don't do that... What matters is the treatment... The patient's treatment is the top priority; you have to coordinate the other conditions around it."

This approach indicates that the physician does not perceive themselves as responsible for "resolving" the patient's personal problems, but rather considers it their sole obligation to advance the treatment process as effectively as possible within the given circumstances.

3.3.2. The Self-Care Strategy of Emotional Distancing

Some physicians perceive the maintenance of emotional distance not as indifference, but as a necessary strategy for preserving professional functioning and preventing clinical errors resulting from emotionally driven decision-making. Physicians employ emotional distancing as a protective strategy: controlled empathy, light humor, or redirecting personal emotional responses into practical activities replace full emotional engagement, in order to prevent affective interference with clinical judgment. Although this approach contributes to professional sustainability, it may also reduce the family's perception of empathic engagement. Physician No. 4 explained this perspective as follows:

"Usually, when you work in the oncology field, you should be less emotional. If you are emotional, it leads to mistakes. I like the patients, I joke with them, but I'm usually not an emotional person because I think medical treatment is not something where emotions should enter; if they do, they change the course of treatment. I try, if I am affected by something, to channel it into a different path."

This orientation reflects a defensive coping style aimed at ensuring professional survival in the context of continuous exposure to suffering and death.

3.3.3. Unvarnished Truth-Telling Without Emotional Buffer

Some physicians believe that the direct and unmitigated disclosure of medical realities—even when discouraging—constitutes an inherent component of their professional responsibility. This form of "candor" facilitates the formation of realistic expectations but, at times, conflicts with societal expectations for "hope-giving", thereby placing physicians in situations where they are confronted with family members' demands for reassurance and subsequent criticism. Physician No. 7 referred to this experience as follows:

"Some come and say, 'For God's sake, give us hope and speak positively;' I say, 'What do you mean by positive? I am stating the reality.' I am sometimes criticized for not 'speaking a little better,' but I tell the truth."

This stance reflects a form of deontological orientation, in which truth-telling is given priority over immediate psychological comfort.

3.3.4. Inducing Guilt to Ensure Treatment Adherence

In certain situations, to ensure compliance with therapeutic instructions—particularly when direct methods prove ineffective—physicians resort to psychological influence strategies, such as inducing guilt in parents. Some physicians employ messages that frame parents as morally responsible for the consequences of non-adherence, thereby increasing the likelihood of treatment compliance. In this context, the physician conceptualizes the relationship as an instrument for enforcing treatment follow-up. Physician No. 7 explained this approach as follows:

"For example, I talk to the fathers... 'You didn't bring him and...' I don't let it go easily... and I tell him, 'Do you know what you are doing to the child?'"

This tactic, which may fall within the domain of psychological manipulation, reflects a strong inclination toward controlling the clinical situation and ensuring adherence at any cost.

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3.3.5. Lowering Expectations to Prevent Legal Consequences

Given the prevailing socioeconomic context and the increasing tendency toward litigation, one cautious and pragmatic strategy involves the early management of patient expectations. In this approach, the physician provides a conservative and low-hope prognosis, thereby both protecting themselves from potential legal repercussions and creating a context in which a successful treatment outcome can be perceived as a positive "surprise." Physician No. 4 illustrated this strategy using a proverbial expression:

"Jokingly, I say... 'Expect the worst, so you'll be satisfied with a fever'... It's better to lower the patient's expectations so that if a good result is achieved, they say, 'Thank you'... Otherwise, you will constantly have to deal with their discontent."

This perspective clearly demonstrates how legal and social considerations directly shape physicians' communication styles.

3.4. Theme 4: The Informative Physician–Patient Communication Model

One of the emerging patterns identified in this study was the "informative physician–patient communication model." In this model, the physician provides the patient and family with clear and explicit information regarding available treatment options and keeps them informed about the therapeutic process; however, the final decision regarding the treatment trajectory ultimately remains the physician's responsibility. This approach is grounded neither in a paternalistic framework nor in a consultative, shared decision-making model. Rather, the physician primarily assumes the role of a reporter of information. This pattern, which is deeply embedded in cultural contexts, simultaneously reduces the physician's burden of responsibility while keeping the family informed, without transferring decision-making authority to them.

3.4.1. Transparency in Presenting Treatment Options

Within this perspective, the physician considers it a professional obligation not only to present the optimal treatment option, but also to clearly articulate the clinical rationale underlying that choice to the patient. This practice is intended to enhance patient awareness and promote acceptance of the proposed treatment. Physician No. 1 explicitly adheres to this principle:

"My personal belief is that the patient must be fully aware of the situation... I explain to them that for this reason, for that reason, I must do this... If treated, the outcome will be this way; if not treated, it will be that way."

This approach fosters trust through transparency and transforms the patient from a passive recipient of care into an informed collaborator.

3.4.2. Ultimatum for Informed Decision-Making

In certain cases, the physician explicitly articulates the medical reality, the available treatment option, and the consequences of refusing treatment with full clarity. This form of "ultimatum" is not intended as a threat, but rather as a means of ensuring the patient's complete understanding of the situation and clarifying their responsibility. That is, when the clinical condition is urgent or critical, the physician adopts a decisive and firm mode of expression, while still preserving the dignity of the patient's right to choose, in order to convey the immediacy and necessity of therapeutic intervention. Physician No. 5 described this approach as follows:

"I tried to tell them frankly... This is the treatment, and nothing else. Frankly! Because if you are not frank, it's like placing a live coal between a mattress and a quilt; the smoke will rise... Nothing remains hidden."

This approach reflects a communication strategy in which decisiveness is employed to secure informed awareness, rather than to impose coercion.

3.4.3. Explanation Tailored to Patient's Comprehension

While adhering to the principle of informing, the physician adjusts the content and complexity of information according to the patient's knowledge, education, and capacity for understanding. Explanations are tailored to the patient's level of education, health literacy, and the family's expectations in order to achieve genuine comprehension and to avoid presenting unnecessary or overly burdensome information. This perspective reflects the flexibility inherent in the informative model. Physician No. 8, drawing on his clinical experience, stated:

"You must tell the patient's guardians the information based on their understanding... You are obliged to... ensure the details you provide about the treatment are at [their] level of comprehension."

This approach demonstrates that effective communication does not lie in the uniform delivery of information to all patients, but rather in the customization and contextual tailoring of information to the audience.

3.4.4. Information Disclosure as a Legal Shield

Some physicians explicitly acknowledge that providing clear explanations and devoting sufficient time to patients, in

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addition to being an ethical obligation, also serves as a strategy for preventing complaints and legal complications. The experience of Physician No. 8 reinforces this perspective:

"These complaints mostly stem from... the physician not having interacted with the patient as well as they should have... If the physician invests time... explains... it doesn't happen this way."

This view highlights the pragmatic dimension of the informative model, transforming it into an investment in professional safety.

3.5. Theme 5: Shared Decision Making

This communication model corresponds to a framework in which both the physician and the patient (and family) assume active and complementary roles in the therapeutic process. In treatment-related decision-making, the patient's goals, values, and treatment preferences, as well as the available therapeutic options, are openly discussed, and relevant information regarding each option is provided to the patient. In contrast to pure paternalism or pure consumerism, this model is fundamentally based on collaboration and mutual commitment, which are considered essential prerequisites for achieving optimal clinical outcomes.

3.5.1. The Necessity of Cooperation

From several participants' perspectives, continuous and sustained patient cooperation is a fundamental prerequisite for treatment effectiveness. These physicians conceptualized treatment as a triadic construct consisting of (1) the physician and healthcare team, (2) the treatment/medication, and (3) the patient/family, such that the absence of any component undermines the success of the therapeutic process. Repeated non-adherence by the patient imposes a substantial clinical and ethical burden on the healthcare team and may, in some cases, lead to the decision to terminate follow-up care. For example, Physician No. 1 described this principle as follows:

"In the process of treatment, the physician and the medication function as tools that lead to the patient's recovery. Another side is the healthcare team—physicians and other staff involved in treatment—and the third side is the family. If even one of these three sides is missing, we will not succeed. That is, if I, for instance, am absent, or if I lack sufficient knowledge and do not provide appropriate treatment, the process will inevitably fail."

In one case, an adolescent patient with leukemia demonstrated persistent non-adherence to the treatment regimen, marked by repeated and prolonged absences. This pattern resulted in recurrent relapses, and each time the medical team struggled to bring the patient into temporary remission. Upon the third relapse, the physician informed the family that, *"Given the history of non-cooperation and the sensitivity of the condition, it is no longer possible to continue treatment,"* and the patient was subsequently not admitted for further care.

3.5.2. SDM-Oriented Behavior with a Paternalistic Attitude

In this model, elements of shared decision-making (SDM) are implemented within a framework that retains traces of paternalism. The physician makes an effort to engage the family and allow them time for deliberation. However, in practice, strategies such as suggestion, guided dialogue (aimed at avoiding direct accountability and mitigating potential consequences), and reframing medical advice in the family's own language are employed to subtly steer the decision toward the clinically optimal option, without applying explicit coercion. One participant described this process as follows:

"We try not to position the family against us. We explain the logic of the treatment and the child's future health, but ultimately, we allow the parents to decide. Because if we force them, any outcome will be viewed through our lens. Our work requires behavioral skill. I must act in a way that leads parents to arrive at the logical conclusion themselves and articulate it in their own words. The formula is: I empathize but do not sympathize. I say, 'You are the decision-makers; if it were my child, I would do this.' In the end, trust is the most important factor."

This pattern reflects a hybrid decision-making style in which guided autonomy is exercised within an underlying paternalistic orientation, allowing the physician to balance clinical responsibility with relational risk management.

3.6. Theme 6: The Hedonistic Model

In contrast to the pragmatic model, the primary objective of the relationship in this pattern is to maintain the patient in a psychologically pleasant and emotionally comfortable state, such that other considerations recede to secondary importance. In other words, the physician's perceived duty in this model is to safeguard the patient's sense of well-being and to comply with the patient's wishes, even when these wishes extend beyond, or potentially conflict with, other professional obligations.

3.6.1. The Imperative of Unconditional Patient Compliance

This subtheme reflects the physician's perception of a moral duty to comply unconditionally with the patient's wishes,

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even when the patient's behavior does not align with the treatment preferences of the medical team. This acceptance is grounded in the belief in the family's/patient's right to decision-making, and is accompanied by efforts to influence behavior through advice, persuasion, and dialogue. In this pattern, the physician appears to draw a boundary between ethical influence and coercion.

For example, Physician No. 9 described this stance as follows:

"Sometimes the patient has expectations, and these are all their rights. Situations arise that don't align with our treatment approach. For instance, not bringing the child on time for appointments, not obtaining medications, not feeling sufficiently responsible, prioritizing personal matters over the patient's needs—even if they behave harshly, the patient is always right... I might lose my temper too, but rest assured if I am angry, it's definitely influenced by the illness or unfavorable conditions... But ultimately, the patient is right, even if they miss appointments, don't take their medication... because they are children. Their advocates are their parents, and conflict will inevitably arise. However, parents have the right to decide, and we proceed through advice, discussion, pleading, and supplication."

3.6.2. Framing for the Induction of Optimism

Within this model, the physician deliberately adopts a selective and directional approach to information disclosure to preserve the patient's sense of hope and optimism. In this context, "induced optimism" functions as a tool for maintaining the emotional equilibrium of both the patient and the family, particularly under conditions in which the medical reality could otherwise lead to despair and helplessness. From a cultural perspective, this form of framing is congruent with the religious and hope-oriented values of Iranian society, positioning the physician not merely as a source of knowledge, but also as a source of meaning. Physician No. 9 referred to this practice as follows:

"I try to say it pleasantly... Given the difficulties and high mortality, we prioritize hope. The belief that God and miracles exist helps a lot."

3.6.3. The Difficulty of Disclosure in Cases of Medical Error

In some circumstances, physicians decide to prioritize the patient's emotional stability and refrain from full transparency in disclosing a medical error. Factors contributing to such decisions include anticipated patient distrust, the perception that family members more readily accept death due to illness than death resulting from medical error, and delays in timely disclosure. The narrative of Physician No. 2 illustrates this dilemma:

"Sometimes, disclosing a medical error creates a dilemma for me. For instance, when a high-risk newborn with a low chance of recovery dies earlier due to a medical error, and I find out three days later. On one hand, my ethical principles tell me I must inform the family of the error, but on the other hand, I know that telling them would cause severe distrust. The family can more easily accept death from a malignant disease than believe their child was lost due to a medical mistake. In this specific case, even though my conscience said I should tell the truth, I couldn't do it, and this remained an ethical problem for me."

3.7. Theme 7: The Empathic–Emotional Communication Model

In this model, the physician–patient relationship is constructed based on shared experience, empathic concern, and emotional attunement. In contrast to distant and purely cognitive approaches, within this framework the physician becomes engaged not only at the cognitive level (understanding the patient's condition) but also at the emotional level, participating affectively in the patient's experience. This type of relationship may enhance intimacy and trust within the therapeutic alliance; however, it simultaneously increases the physician's psychological burden and risk of emotional exhaustion. Within the Iranian cultural context—where empathic engagement in medical care is often regarded as a humanistic and valued attribute—this communication model represents one of the prevalent and socially accepted patterns of physician–patient interaction.

3.7.1. The Inevitability of Empathy

Several physicians participating in the study believed that, within clinical settings—particularly when dealing with pediatric patients—complete emotional detachment is neither feasible nor desirable. Physicians do not perceive themselves to be immune to the emotional impact of patients' suffering and regard empathy in this context as a natural and inherently human response. Referring to the unavoidable emotional susceptibility of physicians, Physician No. 6 stated that empathy constitutes an intrinsic dimension of the human nature of this profession:

"How could it be otherwise?... Sometimes we say we shouldn't empathize, but it's impossible! You go to a corner by yourself... After all, we are human. How could we not be affected? How could our hearts not tremble? In a few years, a robot will have to do our job."

3.7.2. Reciprocal Emotional Impact Between Pediatric Patients and Physicians (Blurring of Therapeutic Boundaries)

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This subtheme refers to a phenomenon in which the emotions of the physician and the patient mutually influence one another, leading to a blurring of professional therapeutic boundaries. Physician No. 10 described this emotional entanglement as follows:

"When our patient's platelet count rises, we become happy, and when they develop neutropenia, we become distressed... Our criterion for happiness and sadness is the patient's condition... This is our world."

Similarly, Physician No. 5 spoke about the heavy emotional burden of such relationships:

"Children bond with you... When they face problems, it shatters your nerves... I keep going and saying 'La ilaha illallah,' (an Islamic invocation meaning 'There is no god but Allah') to calm myself, even at home I keep waking up at night feeling unwell, I cannot sleep, I keep tossing and turning... even when I fall asleep around three in the morning, I wake up repeatedly... It's like a seed you plant that doesn't sprout; it's upsetting."

These narratives indicate that the physician, in the treatment process, is not merely an observer, but becomes actively involved in the patient's emotional cycle. As a result, the boundary between professional empathy and personal emotional involvement may at times become blurred, and the physician may come to emotionally experience the patient's suffering.

3.7.3. Need for Resilience in Repeated Pediatric Encounters

Physicians working in pediatrics and oncology emphasize that practice in this field requires a distinct level of emotional capacity. Physician No. 4 highlights the emotional difficulty of this specialty as follows:

"The difference between adult and pediatric oncology is that people are more sensitive toward children... When a five-year-old gets cancer, that's it, the whole situation is different... An ordinary, indifferent physician cannot do it; one must have specific criteria to be able to work here."

In this account, resilience is framed not merely as a professional skill, but as a requirement for survival in the work environment. To endure within a relationship saturated with pain and loss, physicians need exceptional emotional strength to remain empathetic while also protecting themselves from emotional burnout.

3.7.4. Structural Empathy: Recognizing Systemic Difficulties

In some cases, physicians' empathy extends beyond the patient's clinical condition and includes an understanding of the structural pressures and systemic inequalities within the healthcare system. Physician No. 9 describes this as follows:

"If I were in the patient's place, I would never be in Iran... A patient has to show respect to the security guard, reception, secretary, support staff, and nurse... They must bow from the moment they enter until they reach their physician."

This statement reflects a form of structural empathy, meaning that the physician understands the patient's suffering not only at an individual level but also at a social and institutional level. Such empathy leads to a deeper understanding of the patient's experience and contributes to making physician–patient interactions more humane.

3.7.5. The Physician as an Interpersonal Emotion Regulator

In this sub-theme, the physician plays an active role in modulating the patient's emotions through empathic skills. This process helps the patient come to terms with the experience of illness and become relieved of feelings such as guilt and helplessness. Physician No. 10 explains:

"I talk a lot with my patients. At the first stage, they are in denial, and then they feel guilty—thinking they must have done something wrong for this to happen to them... I let the patient's mother openly express her pain and distress... at that point the stress comes out, and I help resolve the inner conflicts for her... afterward, she can go through the stages of treatment more steadily."

In this account, the physician functions as an emotion regulator, assuming a role similar to that of a psychotherapist. Through empathic listening, the physician provides an opportunity for emotional release and meaning-making of suffering, thereby facilitating illness acceptance and treatment adherence.

4. DISCUSSION

The findings of this phenomenological study provide a comprehensive view of the dominant communication styles governing the relationship between pediatric hematologist–oncologists and patients in Iran, from the physicians' perspectives. Some of the results indicate that the pattern of "cultural paternalism" in Iranian culture is not merely a unidirectional imposition by the physician, but rather reflects a form of implicit cultural consensus between both parties. In other words, contrary to traditional interpretations of paternalism that regard this model solely as a manifestation of unilateral medical dominance, our data suggest a bidirectional and consensual dynamic in this relationship. This finding is consistent with recent research on the "varieties of paternalism in physician–patient

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communication," which shows that paternalism can take diverse forms ranging from consensual to authoritarian [21]. Within this model, the physician determines the diagnostic and therapeutic course based on their expertise and competence, while the patient or family often accepts—and in some cases actively seeks—this role. For certain patients, the physician's decisiveness and even assertiveness are interpreted as indicators of the seriousness of the illness and the necessity of treatment; this, in turn, contributes to increased treatment adherence and therapeutic motivation. Therefore, "authoritativeness" in this context does not merely represent a commanding behavior, but rather functions as a shared communicative strategy and a practical tool in which both physician and patient play an active role. A similar finding has been reported in an ethnographic study conducted in emergency settings, showing that a paternalistic culture can be accepted as part of the "logic of care" [23].

Nevertheless, this pattern is not without challenges. In certain situations, physicians encountered a conflict between the principle of beneficence and the principle of autonomy. In cases where the family—particularly the father as the legal guardian of a child with a serious illness—makes a decision that contradicts the patient's vital best interests due to cultural beliefs or cognitive limitations, the physician feels ethically obligated to intervene. However, the lack of legal support or existing social constraints often generates a sense of helplessness and psychological pressure for the physician. This situation is consistent with cross-cultural reports indicating that restrictions on patient autonomy can place physicians in morally distressing positions [24].

On the other hand, some physicians regard "absolute truth-telling" and the full delegation of decision-making authority to the patient as incompatible with Iranian culture. They believe that such an approach is derived from Western standards and does not align with the expectations of Iranian patients. Instead, repeated hope-giving and gradual disclosure of information are presented as culturally grounded and more compatible practices for Iranian patients. From this perspective, paternalism is viewed not as coercion, but as a supportive and culturally congruent intervention that may reduce patients' psychological distress and facilitate the treatment process. At the same time, critical findings from Middle Eastern studies in Islamic countries such as Saudi Arabia also confirm the strong presence of rigid paternalistic culture and seek pathways to balance this cultural orientation with patients' rights to choice and autonomy [25, 26].

Moreover, in many cases, families actively delegate the responsibility for decision-making to the physician. This form of "delegated guardianship" reflects a type of institutional and cultural trust in the physician and, contrary to common assumptions, does not necessarily imply the deprivation of the patient's or family's authority. Rather, this delegation is not rooted in incapacity, but represents a form of culturally and institutionally grounded trust in the physician. In this sense, it constitutes a type of "indirect participation," whereby the family consciously and intentionally transfers responsibility to the physician. Similar findings in the literature on intercultural physician–patient communication emphasize that in some cultures, the deliberate delegation of responsibility to the physician is considered a form of indirect participation [27].

In practice, this pattern represents a form of cultural agreement between the physician and the family, in which the physician assumes the role of a benevolent guardian. Such a pattern suggests that the concept of shared decision-making requires redefinition within the Iranian context; participation does not necessarily equate to direct patient decision-making, but may also include the conscious and active delegation of responsibility to the physician. What is central in this process is the alignment of preferences between the healthcare team, the patient, and the family—that is, the specific orientation each party adopts and prefers. Ultimately, the key factor is congruence between the healthcare team and the family, which enables the highest level of coordination in pursuing therapeutic goals.

In an interesting contrast to the theme of cultural paternalism, the findings of this study reveal another communicative pattern referred to as "defensive consumerism." In this model, the physician adopts the role of a service provider and assigns final decision-making authority to the patient or the patient's family. Although this approach ostensibly reflects respect for patient autonomy, in practice it is largely motivated by caution and the desire to prevent potential legal and judicial consequences. Consistent with this finding, a systematic review by Lorenc et al. (2024) demonstrated that many physicians across different contexts transfer decision-making to patients as a strategy to protect themselves against legal repercussions and possible litigation [28].

The observed examples indicate that by emphasizing statements such as "you decide" or "the final choice is yours," the physician, rather than seeking genuine shared participation, primarily attempts to relieve himself or herself of ultimate responsibility and to demonstrate the absence of professional neglect. This finding is consistent with the study by Eftekhari et al. (2023), which showed that physicians in Iran and other countries, in order to reduce the risk of litigation, transfer decision-making authority to

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patients instead of actively guiding the therapeutic process [29].

In some cases, this pattern escalates to a level of detachment and disengagement from the therapeutic relationship, whereby the physician refrains from exercising professional judgment even when the patient's choice directly conflicts with therapeutic goals, and leaves the continuation or termination of treatment entirely to the patient. Game-theoretical analysis by Delpini and Russu (2023) similarly demonstrated that under conditions of perceived litigation threat, physicians are more likely to adopt defensive strategies and even provide suboptimal treatments [30].

In the present study, it was also found that in more critical situations—particularly when patients or families make illegal demands or exhibit aggressive behaviors—physicians may decide to limit or terminate the therapeutic relationship in order to protect themselves, intervening only under emergency conditions. This situation parallels legal reports indicating that, when confronted with legal pressures and the threat of complaints, physicians sometimes formally terminate the therapeutic relationship to avoid allegations of unlawful abandonment of care [31].

Such examples indicate that "defensive consumerism" is less a conscious, patient-centered choice grounded in respect for autonomy, and more a reactive response to legal, social, and ethical pressures that compel physicians to retreat from their guiding and supportive role. This interpretation is consistent with a systematic review published in BMJ Open (2024), which conceptualizes defensiveness not as a positive professional choice, but rather as a reaction to external pressures and legal threats [28].

Following the examination of the two patterns of "cultural paternalism" and "defensive consumerism," each of which in different ways reflects the interaction between culture, ethics, and legal pressures, the findings of the present study point to the emergence of a third pattern referred to as the "pragmatic and role-oriented model." This transition indicates that physicians' communicative styles are not positioned solely along a continuum between authoritarianism and defensiveness, but may also evolve toward a form of professional realism.

In this model, the physician defines his or her role solely as that of a technical specialist whose primary obligation is the advancement of the treatment protocol, while the patient's emotional or familial issues gain relevance only insofar as they directly interfere with the therapeutic process. This approach is rooted in professional realism and the management of emotional burden, enabling physicians to maintain therapeutic focus when confronted with difficult circumstances. A comparable finding was reported by Eskelinen and Ollonen (2014), who showed that emotional distancing may function as a self-care mechanism for physicians, although it may be perceived by patients as a form of indifference [32].

One of the most salient features of this pattern is the decisive separation of patients' personal problems from the treatment process. From the perspective of these physicians, crises in the patient's personal life—despite their importance—should not interrupt the independent and vital course of medical treatment. This approach, which assigns absolute priority to life-saving intervention, although derived from professional realism, may nevertheless be interpreted by patients as a neglect of their holistic existence. Consistent with this finding, a review by Parker et al. (2020) in primary care demonstrated that physicians at times withdraw from emotional exchanges with patients in order to prevent disruption of the therapeutic trajectory [33].

In parallel, the strategy of "emotional distancing as a self-care mechanism" plays a prominent role. Many physicians regard the maintenance of controlled empathy not as indifference, but as a professional necessity to prevent burnout and to ensure that clinical decision-making remains free from the disruptive influence of intense emotions. This stance represents an adaptive response to continuous exposure to suffering and death [32].

At the communicative level, this model manifests itself through "unvarnished truth-telling without emotional buffer." For this group, forthright disclosure of medical realities—regardless of their distressing nature—is considered an inseparable component of professional responsibility and the foundation for the formation of realistic expectations. This perspective often stands in direct tension with the cultural expectation of "giving hope," thereby exposing physicians to criticism from patients' families. A similar finding was reported by Siraj et al. (2024) in the Bangladeshi context, demonstrating that blunt truth-telling in non-Western cultures may conflict with prevailing norms of hope-oriented communication [8].

At the opposite end of this spectrum, more controlling tactics, such as "inducing guilt to ensure treatment adherence," were also observed. This strategy, which is typically employed when direct approaches prove ineffective, seeks to compel compliance by imposing a sense of responsibility upon parents. Although this method may lead to improved adherence in the short term, it can undermine relational trust and impose an additional psychological burden on families.

Accordingly, under the influence of the current high-risk clinical–legal environment, this model also tends toward "cautious management of expectations for legal

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immunization." Within this strategy, the delivery of a guarded and low-hope prognosis serves not only as a means of creating a "positive surprise" in the event of therapeutic success, but also functions as a defensive shield against potential future litigation. This finding is consistent with the literature on "cautious prognostication as a risk management tool," which indicates that physicians lower levels of conveyed hope in order to protect themselves from legal repercussions [34].

Thus, although Theme 3 emphasizes professional realism and role orientation, it remains positioned along the same continuum as the two preceding themes: on the one hand, it stands in contrast to cultural paternalism by minimizing the emotional and supportive burden of the physician's role; on the other hand, it overlaps with defensive consumerism insofar as risk management and legal self-protection remain salient. This interconnection among the three patterns demonstrates that physicians' communicative styles in Iran are not static, but rather dynamic and shaped by intersecting cultural, social, and legal pressures.

Following the identification of cultural paternalism, defensive consumerism, and subsequently the pragmatic/role-oriented approach—each of which illuminated different dimensions of authority, caution, and realism—the findings now point to a model centered on transparency and reporting, namely the informative physician model.

The informative physician model is a pattern that critically balances two fundamental principles of medical ethics, namely veracity and beneficence, with the aim of transforming the patient and family from passive recipients into informed agents. In contrast to traditional paternalistic models, this approach emphasizes explicit disclosure of therapeutic options and the transparent articulation of the rationale underlying clinical choices, as it conceptualizes transparency not merely as an ethical obligation but as the very foundation of therapeutic trust [35].

Comparable findings have also been reported in cross-cultural research, indicating that in Asian societies, direct truth-telling may simultaneously serve as a tool for patient empowerment and a mechanism for the reproduction of physician authority [36].

The peak of this transparency is manifested in the concept of "laying down the ultimatum for informed decision-making." In critical situations, the physician communicates the clinical reality and the consequences of non-adherence in a firm and unreserved manner, a stance that closely resembles cultural assertiveness within the paternalistic model. This behavior reflects the tension between maintaining empathy and conveying clinical urgency, whereby the physician, through choosing decisiveness, seeks to fully transfer active and responsible awareness to the family so that their understanding reaches a level of perceived inevitability [37].

At the same time, this model is moderated by the subtheme of "information customization." The physician adjusts the level and content of explanations according to the patient's health literacy and cognitive capacity. This indicates that genuine awareness lies not in the sheer volume of information, but in the quality of comprehension calibrated to the recipient's capacity. This perspective is consistent with the literature on patient-centered communication, which emphasizes the necessity of tailoring messages to the characteristics of the audience [35].

Ultimately, physicians perceive this model not only as an ethical obligation, but also as a pragmatic strategy for the prevention of legal complaints. Accordingly, disclosure becomes a tool for risk management and professional safety, a notion that has also been identified in prior studies as one of the latent motivations underlying truth-telling [38]. Thus, within the spectrum of communicative models, the informative physician model occupies a middle position: distanced from traditional paternalism, yet still distinct from fully patient-centered shared decision-making.

Following the examination of patterns ranging from cultural paternalism to defensive consumerism and pragmatic role-oriented realism, which collectively delineated a spectrum of authority, caution, and realism, a distinct model now emerges that is grounded in reciprocal cooperation and mutual trust—namely, the mutual participation model. The model of mutual participation identified in this study is based on the premise that favorable clinical outcomes in pediatric oncology depend on an interactive triad, in which continuous cooperation of the patient and family, alongside the physician's competence and the effectiveness of treatment, constitutes an absolute necessity. A comparable finding was reported in the systematic review by Juárez-Villegas et al. (2021), which demonstrated that decision-making in childhood cancer is often shaped through a three-way interaction among physician, family, and patient [39].

Within the subtheme of the "necessity of bilateral cooperation," this model explicitly asserts that patient autonomy must be accompanied by mutual accountability. In other words, repeated and deliberate non-adherence (such as prolonged absences from treatment) may lead to difficult and ethically burdensome decisions, including the termination of patient follow-up. Under such life-threatening conditions, this reflects a form of outcome-contingent autonomy, in which autonomy is conditionally constrained by responsibility. This finding is consistent with

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the results of Greene et al. (2024), who, within the framework of decision-making in pediatric precision medicine, emphasized the necessity of linking autonomy with accountability in order to ensure optimal clinical outcomes [40].

However, the practical implementation of this mutual participation is complicated by the component of "SDM-oriented behavior with a paternalistic attitude." In this approach, the physician applies the principles of shared decision-making (SDM) by explaining the rationale for treatment and providing an opportunity for decision-making; nevertheless, this process often takes the form of a guided dialogue. This finding is consistent with Abdi's (2021) analysis in pediatric oncology, which showed that SDM in practice is more frequently implemented as a guided process, with the physician playing a prominent role in steering the family's choices [41].

The physician employs behavioral and empathic skills to direct the family's decision toward the clinically preferred option (e.g., "If it were my child, I would choose this"), while avoiding overt coercion. This subtle approach serves two primary objectives: first, ensuring the best possible clinical outcome for the child (the principle of beneficence), and second, protecting the healthcare team from potential blame should complications arise, as the choice is ostensibly reconstructed as originating from the parents. This interpretation is aligned with the NICE (2022) SDM guidelines, which emphasize the importance of empathic guidance alongside thorough documentation of decisions in order to mitigate legal consequences [42].

Following the examination of patterns grounded in authority, caution, realism, and transparency, a different model now emerges—one that focuses more than anything on preserving hope and the psychological balance of the patient and family; namely, the hedonistic model. The hedonistic model, derived from the findings of this study, represents a communicative pattern in which maintaining psychological equilibrium and optimism in the patient and family is prioritized over purely pragmatic therapeutic procedures. This finding is consistent with Hedlund's (2008) report, which showed that patients with cancer regard hope and optimism as among the most important psychological resources for coping with illness [43].

This model faces two major ethical and practical challenges. On the one hand, by adopting an attitude of near-total compliance with the patient's wishes (such as non-adherence to appointments or treatment instructions), the physician places the reduction of negative experience above purely medical expertise. In this context, the physician's role shifts from that of a directive authority to an active and insistent advisor, who seeks to align goals through persuasion and counsel rather than command. This situation parallels the findings of Ghorbani et al. (2025) in Iran, which demonstrated that hope and optimism can reduce the caregiving burden on families and improve the quality of therapeutic interactions [44].

On the other hand, this model deliberately resorts to framing strategies to create optimism; that is, information related to poor prognosis or treatment side effects is managed in a way that reinforces an induced sense of hope—an approach which, in the context of life-threatening illnesses such as cancer and in alignment with hope-oriented cultural values, is regarded as a form of caregiving tool. The NCI review (2025) likewise emphasizes that "hope framing" in oncological communication can contribute to improving patients' psychological adjustment, although it always carries the risk of generating false hope [45].

The peak of tension in this model is manifested in the subtheme "the difficulty of disclosure in cases of medical error"; where, in encounters with patients in need of emotional calm or those in terminal stages, the physician prioritizes non-maleficence (avoiding psychological harm) over the principle of absolute transparency, to prevent the destruction of trust and the psychological consequences associated with confronting death due to human error. This tension between truth-telling and harm avoidance has also been identified in the bioethics literature as one of the fundamental challenges in end-of-life care [46, 47].

Overall, the hedonistic model demonstrates that in oncology—particularly in critical conditions—the physician achieves a complex balance between duty-based ethics and consequence-based ethics in order to preserve the patient's psychological quality of life. This finding is consistent with the analysis by Amer (2019), which indicates that no single ethical theory can adequately address all clinical situations, and that physicians are inevitably required to strike a balance between deontological and consequentialist principles [48].

Following models that emphasized authority, caution, realism, transparency, and even hope-centeredness, an approach now emerges that is founded more than anything else on emotional bonding and mutual empathy—namely, the empathic–emotional communication model.

The empathic–emotional model is one of the core findings of the present study, offering a vivid portrayal of the deeply human nature of therapeutic relationships in pediatric oncology, and clearly distinguishing it from purely technical approaches. This model is grounded in shared experience, empathic concern, and compassionate resonance, and in the

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Iranian cultural context—where human relationships in care are highly valued—it assumes even greater significance.

The findings show that when confronted with children's suffering, empathy for the participating physicians was not a choice, but an inevitable and natural reaction ("How could our hearts not tremble?"). This stands in contrast to some Western models that emphasize maintaining emotional distance as a strategy for preventing burnout [49].

However, this emotional closeness gives rise to the phenomenon of reciprocal emotional influence, whereby the patient's clinical indicators (e.g., "when our patient's platelet count rises, we feel happy") become the physician's internal criteria for happiness and distress, and the boundary between professional compassion and personal emotional involvement becomes blurred. This entanglement imposes a heavy emotional burden on the physician ("I wake up at night feeling unwell"), thereby highlighting the necessity of possessing greater resilience capacity as a vital requirement. A review by Zhou and colleagues likewise indicates that high levels of empathy may correlate with burnout and therefore require dedicated resilience-enhancing strategies [50].

The importance of empathy in this model is not confined solely to the clinical level; rather, it extends to an understanding of the structural hardships of the treatment system (such as administrative pressures and systemic inequalities), guiding physicians toward adopting a more human-centered stance toward the patient's lived experience. This finding is consistent with the analysis by Blazin and colleagues (2018), who demonstrated that empathic communication in pediatric oncology not only strengthens the therapeutic relationship but also facilitates a deeper understanding of systemic barriers [51].

Finally, this empathic model gains a prominent therapeutic dimension through the subtheme of the physician as an interpersonal emotion regulator. In this process, the physician—by engaging in deep listening and providing opportunities for emotional discharge—assumes the role of a psychological facilitator, enabling the patient and family to move beyond the initial stages of denial and guilt and to become prepared for a more stable initiation of treatment. This finding is consistent with models of interpersonal emotion regulation in therapeutic interactions, which demonstrate that empathy can directly influence illness acceptance and treatment adherence [52].

5. CONCLUSION

The findings of this study indicate that the communication styles of physicians in pediatric hematology and oncology in Iran exist along a dynamic, context-dependent spectrum (**Figure 3**). This spectrum ranges from cultural paternalism, which is grounded in authority and an implicit cultural agreement, to defensive consumerism, which is primarily a reaction to legal and social pressures, and further extends to role-based/pragmatism and the informing physician model, both of which emphasize realism, transparency, and risk management. Subsequently, models such as mutual participation, which is based on the integration of autonomy and accountability, the hedonistic model, which focuses on hope and psychological quality of life, and finally the empathic–emotional model, which places the greatest emphasis on human connection and emotion regulation, complete this spectrum.

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Conflict of interest

The authors declared no conflict of interest.

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Ethical statement

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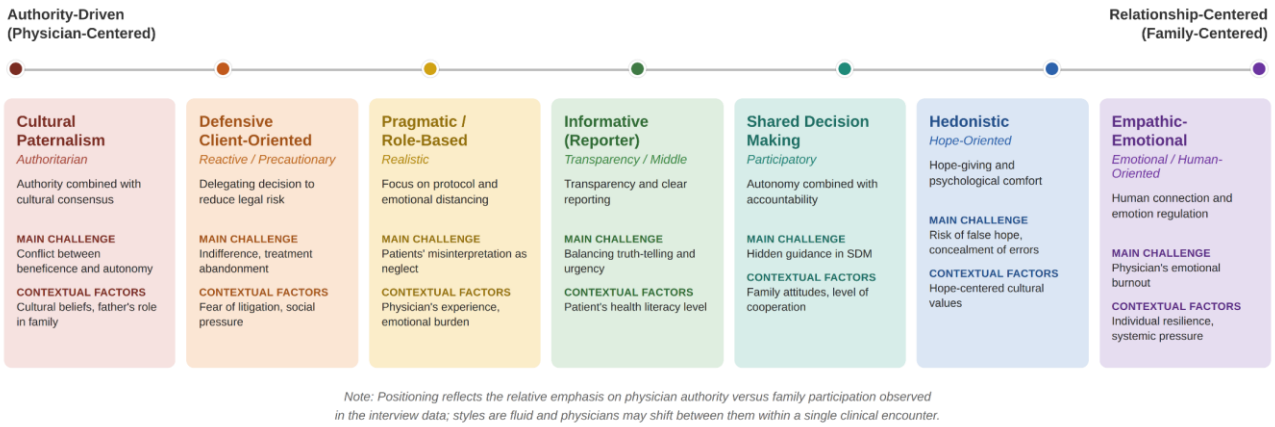

Figure 3. The Spectrum of Physician–Family Communication Styles. Conceptual model summarizing the seven communication styles identified in this study, positioned along a fluid continuum from authority-driven to relationship-centered care.

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