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Truth-telling and emotion management towards work efficiency: A field study in Indian palliative care

**Truth-telling and emotion management towards work efficiency: A field study in Indian palliative care**

The study explores how strategic use of truth-telling and emotion management in a deeply emotional context such as palliative care increases work efficiency. Although the role of palliative care is to provide pain management to terminal patients, a lot of national variations exist. In India for example, false hope is widely used by doctors during interaction with patients. Using ethnographic observations in Indian palliative care setting as my data, I show how use of emotions such as anger, fear and false hope helps doctors to treat patients in a more efficient manner. In a hospital with overload of patients such strategic use of emotions helps doctors to attend many patients within a certain time. Additionally, the paper discusses how cultural belief of family members, that hiding information from patients is "kind and not cruel" encourages doctors to use false hope. The paper also examines whether doctors face any ethical dilemmas for using false hope.

**Key Words: Palliative Care, Emotion, Efficiency, Negotiation**

## Introduction

Doctors' dilemmas regarding whether to tell the truth to patients have been a subject of worldwide ethical debate. As newer models of medical ethics develop "in the individualistic soil of North America" and are introduced to other countries with contrasting moral traditions, it raises the question as to whether the same medical ethics should be universally accepted (Pellegrino 1992: 1734). Truth-telling is a critical aspect of medical ethics because disclosure of truth and withholding of truth can have both positive and negative effects. As Pellegrino pointed out, the extent, process, and timing of truth-telling are factors that do not have a ready formula.

Truth-telling can directly influence patients' hope which in turn may influence their chances and speed of recovery. Previous work has shown that sustaining high hope has positive health benefits for a wide range of patients with terminal (example cancer), chronic (example fibromyalgia) or other kinds (example spinal cord injury) of illness (Affleck and Tennen 1996; Elliot et al. 1991; Taylor 2000). However, there may exist a lot of variation cross-culturally on what aspect of hope one focuses which in turn may influence how doctors employ hope management techniques. For example, while Americans have a focus on the prudence of hope (whether it is realistic to hope), Asians have a moralistic focus (whether it is appropriate to hope) (Averill, Catlin and Chon 1990). In Asian countries, it is socially acceptable to hope for something as long as it is not immoral. Therefore, during disclosure, softening the seriousness of an illness to a terminally ill patient is acceptable, because it encourages a patient to continue to hope for a cure (even when it is unrealistic). Physicians try to manage the emotions of patients by not telling patients that they have cancer in order to sustain hope and prevent depression (Swinbanks 1989, Gordon 1990, Beyene 1992).

The goal of palliative care is the same worldwide, yet national variations may exist when it comes to truth-telling. In certain cultures, communication of disease with a patient is seen as harmful (Grassi et al. 2000); and doctors' views can be shaped by the interplay of the culture of western medical practice and their local culture. For example, Long and Long (1982) provided examples where Japanese doctors believed that revealing cancer diagnosis to patients is against medical ethics as cancer is equivalent to death. American doctors in the sixties had a similar notion as they voiced, "Telling is the cruelest thing in the world" and "No one can be told without giving up and losing all hope" (Oken 1961: 1125). Beyene (1992) observed that, although honesty is considered the most highly valued character trait in Ethiopian culture, doctors are comfortable with bending the truth. For example, a patient with a 40% survival chance will be told that his disease is 100% curable. Such a saying is not considered as a deviation from the truth, indicating that truth is socially defined/constructed.

The different practices of disclosure of disease are closely related to the hope of patients. Glaser and Strauss (1965: 123) note that when doctors convey the message that a patient's condition is terminal, they do not predict the time when they will die in order to sustain some hope. Additionally, they would also manage the hope of patients by mentioning death as a means to connect to God, or that some curative medicine may come in shortly in the recent future. A palliative team may manage the hope of patients by helping them to set up realistic goals. For example, a patient who has no chance of survival may still focus on small goals, "These days I do small things. Now I'm determined to keep on dressing myself each day." On the other hand, if the same patient is given false hope of a complete cure by the

doctor, he may say, "I'll spend Christmas in Sydney, Australia, with my son."<sup>1</sup> Palliative care providers can set up goals for patients that are false as false hope is closely related to the well-being of the patient. Snyder et al. (2002) concluded that past research has shown that having false hope can also be beneficial to the mental well-being of patients.

Emotion management is one critical aspect of the work in palliative care performed by doctors. It is defined as the work that "requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others" (Hochschild 1983: 7). The concept of emotion management was first introduced by Arlie Hochschild back in 1975. Hochschild's original work focused on emotion management of the self. Later scholars have extended it to emotion management of others (Francis 1994; Leidner 1999; Lively 2000). Emotion management has been studied across different professions such as flight attendants (Hochschild, 1983), police officers (Stenross and Kleinman, 1989), nurses (James 1989; 1992; Bolton 2000; Henderson 2001), paralegals (Lively 2002) etc.

Anger is one of the most commonly studied emotions in the workplace because of its easy visibility. Scholars have found that anger generally flows from higher status to lower status, can be used to get desired outcomes and people make larger concessions when facing an angry opponent. (Powell 2006, Sinaceur and Tiedens 2005, Van Kleef et al. (2001, 2004). In this article, we argue that doctors open expression of anger help them to avoid patient resistance and increase their work efficiency.

Humor is another emotion which comes into play in palliative care. Humor has been studied extensively by researchers who have worked in hospital settings; while some scholars (Fox 1959; Coser 1960) focused on the functional aspects of humor (it is used by physicians to detach themselves from the grim reality), others have argued that 'genuinely' and 'spontaneously' funny events do happen in such settings (Chambliss 1996: 46). Humor can also be used to ease tension and to produce relief (Sandford and Eder 1984). Smith and Kleinman's (1989) study of medical students showed that humor can be used as a tool to control inappropriate emotions and can lighten the grave atmosphere of taking care of seriously ill patients (Berlyne 1968). Humor contributes to lightening up of the environment of palliative care settings which in turn can help doctors to work more efficiently and focus on the actual treatment of the patients.

The palliative care setting is an example of a context that is inherently emotional beyond what we would expect with a typical situation. This is because people are dealing with the potential deaths of their loved ones. The truth-telling and emotion management is taking place in this deeply emotional context. The emotional feature of the context has the potential to amplify these processes beyond normal contexts (Sugrue 1982).

In this study, we aimed to discern how the strategic use of truth-telling and emotion management in a deeply emotional context such as palliative care increases work efficiency.<sup>2</sup> If doctors spend less time on truth-telling and emotion management for each patient, it helps doctors to spend more time on the actual treatment of the patient. In a hospital with few doctors and heavy patient load, doctors may have to perform truth-telling and emotion management to terminal patients quickly so that they can attend many patients within a

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<sup>1</sup> Quotations taken from Herth (2004: 37).

<sup>2</sup> I define work efficiency as the speed with which doctors were able to attend one patient before moving on to the next patient.

certain time. This paper examines the different strategies of truth-telling and emotion management in Indian palliative care setting.

## **Methods**

The study has been subjected to a Full Board review in the Office of Research Compliance of Indiana University, Bloomington. The data collection for the project was based on observations in the outdoor clinic of a palliative care in a government teaching hospital in India and were followed by semi-structured interviews with the doctors of that unit. There were five professors (senior doctors) in the department and four to six junior doctors comprising of RMOs (Resident Medical Officer) and PGs (Post Graduate students) worked under each of the senior doctors. The field observations were done over a period of two months, consisting of five days a week. In total 200 hours of field observation and five interviews (of the five senior doctors each approximately thirty minutes in length) were conducted. Each professor with his team of RMOs and PGs conducted an outdoor clinic once a week. I would observe the outdoor clinic each day of the week, with a different professor and his team every day. The clinic was housed with the hospital and comprised of one medium sized room. Most of the time there were multiple patients (three to four) inside the outdoor clinic and several more standing just outside the room waiting to be called. In most cases, there were two to three patients inside the room at a time.

The field observations were followed by interviews. One of the key foci in conducting the interviews was to check if my interpretations derived from observations were backed by the interviews. The questionnaire inquired about the issue of truth-telling and the role of hope (including false hope) in such settings: how palliative care team instills hope in the health care seekers and what they saw as the major challenges they faced during truth-telling. The doctors were also asked how palliative care members perform emotion management of patients, families, coworkers and the self.

Before entering the field work, some initial plans were made on what to observe in the field. These were truth-telling and emotion management to patients and families. However, we were also open to observing any related important things that may be occurring in the field. For example, after entering the field, the lead researcher realized how patient workload influences truth-telling and emotion management of the doctors. Once observational data were collected reflection papers were written to understand the theoretical basis of the emotion management and truth-telling processes that were going on in the palliative care setting. After that, the interview questionnaire was constructed, and the interviews were conducted face to face. The qualitative software package ATLAS.ti was used to analyze the data. Using standardized software such as ATLAS.ti helped to improve the rigor of the initial analysis that was based on reflection papers. For example, whether certain codes co-occur in the text was checked. Initially, codes such as “truth-telling” and “efficiency” were used and later on whether one of these codes are frequently accompanied by the other were analyzed.

## **Emotion management towards work efficiency**

In India emotion management of patients is closely related to doctors’ work efficiency. Doctors try to spend as little time as possible in managing patients’ emotions. This is because there is heavy patient load and addressing the emotional needs of patients lead to

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more time with each patient. Doctors prefer to spend as little time as possible in emotion management and instead spend more time on the actual medical treatment of patients.

One strategy that Indian doctors employ to manage the emotions of patients is using a reference frame. They will point out that there are others whose conditions are worse. Below, a doctor tries to motivate a patient by saying that she is not the most unfortunate among the patients who came to the hospital:

A patient was crying, and the doctor says: “Don’t cry at all, there are others whose conditions are worse than yours.”

Patient: “I am alone; I don’t have my husband.”

Doctor: “Here, everyone is alone.”

Here the doctor is discouraging the patient to cry. If patients keep their emotions in check, doctors will feel less pressured to perform emotion management on them. This will help them to work efficiently in a setting where there is a high patient load. Therefore, when patients cry doctors become irritated. For example, when a patient told the history of her illness and then started crying, the doctor angrily replied, “Don’t shout! If you shout you won’t get cured.”

At times, doctors refuse to acknowledge the emotion of the patients and instead continue the treatment. They think that if they focus too much on the patients’ emotions, then they will have to perform emotion management on the anxious patients. For example, when a patient wanted to stop radiation because of discomfort and fear and wanted the doctor to write a note on her behalf, the doctor responded, “We cannot write like that. If a patient comes and says she cannot do the operation because she is scared, then it is patient’s problem.” Not acknowledging the fear helps the doctor to avoid further discussions about the treatment path.

Sometimes doctors use a non-interference strategy in emotion management. If a patient/family is already happy about treatment even if they are understanding the treatment procedure incorrectly, doctors do not make an effort to clarify the misunderstanding. For example, during one of my observations, a palliative patient came with her husband. The doctor saw her and said that the lymph node has been cured. The husband was so happy that he touched the doctor’s feet (as a sign of respect). However, the patient is actually a palliative patient and the husband completely misunderstood and assumed that she has been cured. The doctor told me later that the patient has left side breast carcinoma and has undergone operation followed by chemotherapy and radiation; two years later she was detected with a lymph node in axoma which got cured but she remains palliative.

Here the doctor made no effort to clarify to the husband that the patient’s survival chances did not change even after the lymph node got cured. A detailed discussion of the present health condition of the patient may lead to more questions from the patient/family and may even require more emotion management. By employing a non-interference strategy, the doctor was able to save time on this patient and move on to the next patient.

In another case, a palliative patient’s husband (patient did not come) came and touched a doctor’s feet and said, “You are God.” This patient was advised by the doctor to have oral chemo. At a later stage, her husband told me, “Chemo, radiation is all complete and the doctor told us to take medicines at home. We have a lot of confidence in him.” Again, the palliative patient and her husband do not know that the disease is non-curable at this point and the doctor made no effort to clarify that.

At times doctors will use subtle lies to patients to manage patients' emotions which in turn increases doctors' work efficiency. In India, the availability of morphine is very limited. Doctors in my field site give oral morphine medicine once a week and only to advanced palliative care patients. When less advanced palliative care patients pursue morphine, they scare the patients by pointing to the negative side of the medicine. A doctor labels morphine as a medicine which is "not good" and thereby discouraging its use:

PG: "I have written a stronger medicine (painkiller) this time."

Family member: "Is it morphine?"

PG: "Not this time. If the pain does not recede, will give you morphine next time."

Family: "Please, give it now."

PG: "Not now. It is not good medicine. It has bad side effects."

Here, the family member was unhappy about the delay of morphine because it means that the patient has to wait one more week before he can get the medicine. However, given the limited supply of morphine, the doctor wanted to wait as he wants to be absolutely sure that no other alternative medicines would work. This is when he decides to use fear to discourage the patient about the use of morphine. Instead of discussing the actual problem of morphine availability, he misguides the patient by saying that medicine has negative consequences. This helps the doctor to cut the conversation short, avoid any potential negotiation with the patient and move on to the next patient quickly.

At times doctors will retort to bigger lies during conversations with patients. Patients have a lot of respect for doctors and they rarely display anger towards them. However, if they do express anger, doctors manage the anger of the patients, particularly if there is an error from their side. The doctors take advantage of the patients' lack of education/knowledge to manage this anger. In the hospital, new patients (coming for the first time) are called inside the doctor's chamber once the returning patients have been addressed. These returning patients are treated on a first come first serve basis but sometimes families become angry as due to patient overload when the doctors and the support staff fail to maintain the order and by mistake, those who come later may be called earlier. Each patient has a file and these files are brought to the doctor's table by the support staff. But the order of the files may get displaced as three to four doctors (one professor and other RMOs and PGs) share the same table. Sometimes doctors have to console angry patients who wait too long due to these mistakes. A doctor is trying to appease an angry family member who thinks she has been made to wait too long to meet the doctor:

Doctor: "See we are working very hard. Plus, new patients will be called later."

Family member: "We are returning patients. Someone who came afterward been called before me."

Doctor: "Those patients whose conditions are really bad and won't survive more than fifteen minutes to half an hour are called first."

I have not seen any patient dying in the outdoor clinic. So, this is an exaggeration that the doctor is using to take advantage of the patient's lack of education/knowledge. Managing anger of patients in a quick and effective way helps doctors to work more efficiently as they can spend their time on the treatment.

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At times, the use of humor helps doctors to manage anger and work efficiently. This can be seen in the following excerpt:

An RMO entered the clinic room, saw many patients/families crowding the room and got upset. He asks the doctor (professor) in a sarcastic way directed towards the patients: “Sir, have you called everyone together?”

Doctor (professor) suddenly cracked a joke: “Yes, I have called everyone. If everyone is around it feels like a party.” The RMO and all the patients/families start laughing. The mood of the whole room changes.”

Sometimes, experienced doctors realize that this overcrowding cannot be simply avoided due to structural constraints and getting upset will only delay their own work. So, this kind of humor not only manages the emotions of the doctors working under him, but it also helps emotion (anger) management of self as well as sends a message to the patients that they need to stand outside the room.

The senior doctors (professors) often manage the emotions of the junior doctors (RMOs and PGs). The junior doctors have less experience with working with a lot of patients and at times express anger at the patients. The following excerpt demonstrates such a scenario:

A patient came along with his family and started asking the PG whether their file is there and when will they be called. PG explains with patience that the yellow files are for new patients, the other files are for old patients and that the new patients will be called first. Patient and family continue to ask questions when PG loses patience and asks the professor: “Where is Kavita (support staff who is responsible for bringing the files)?”

Doctor (professor) to PG: “We are Kavita we are Raja (another support staff). In a government set up, we have to work with this mentality.”

At this the PG smiles and her frustration changes to positive emotions.

Here the senior doctor was using humor to dig at the lack of resources in governmental-medical setups. The senior doctors are willing to do this type of interpersonal emotion management perhaps because they believe that for junior doctors with lesser experience working with a huge patient load may at times feel frustrating. Here emotion management takes place from higher status to lower status (professor to PG). The reputation of the individual professors may be the reason for driving them to manage the emotions of people of lower status (PGs). One PG told me that a lot of the professors do private practice separately and if a treatment error occurs due to a PG’s mistake in a government hospital, the professor’s reputation will be damaged which will indirectly affect his private practice.

Doctors often openly express anger when patients are slightly reluctant to listen to their advice on treatment. Doctors become agitated because they need to spend additional time to explain to the patient about the justification of the treatment advice which increases the doctors’ workload. Openly expressing anger increases the doctors’ efficiency because patients stop questioning further. In the following case, an angry doctor tries to convince a patient, who is against radiation and operations, to take radiation:

Doctor (shouting along with a slight snarl): “Take the radiation! Don’t act like a rascal! You are my father’s age but still, I have to talk like this. If you don’t take it, there will be a hole in your throat. Whatever you will eat will get out of your throat. Nobody will come close to you; your family members will throw you out of the house. I am not at all saying



that you will be cured if you take radiation, but you will be much better. What is your fear? Fear of death?”

Patient: “Yes.”

Doctor (still shouting): “Everyone will have to die. So, what else are you afraid of? Afraid of pain? If you take radiation pain will be lessened. Will you take radiation?”

Patient: “Yes.”

Initially, the patient was hesitant to pursue the treatment advised by the doctor. This led to the shouting of the doctor. Facing an angry doctor, the patient decided to yield in.

### **Truth-telling towards efficiency**

Doctors in India generally give false hope to patients. As truth-telling requires emotion management that demands a lot of time; this eventually leads to a decrease in efficiency. Doctors give false hope directly as a strategy to increase efficiency. For example, when a terminal patient came to the outdoor clinic and asked a doctor, “How long will I suffer”, the doctor replied, “Don’t worry, you will be alright soon.” Giving false hope, helps doctors to increase their work efficiency. A detailed discussion of the patient’s present health condition may lead to more questions from the patient and may require emotional management. By giving false hope, doctors are able to save time and move on to the next patient.

Doctors prefer not to openly communicate with patients about their diseases. Instead, they leave it to the family members to decide on how much to tell. As doctors are burdened with patient overload, they pass the responsibility of truth-telling to families. This is evident from what a doctor told me during an interview:

I personally think that based on doctor-patient relationship over here, it should be left to the family that how far the prognosis will be disclosed to the patient, and should it be completely disclosed to the party. The party...will generally and slowly disclose it. Because we at the most, give five to ten minutes time to the patients. So, in these ten minutes, instead of telling that ‘no you will live for only three months’, it is better that the family takes three days’ time and tell the truth slowly to the patient, that their disease cannot be cured etc...then it is much more acceptable to the patient. (interview transcript)

Doctors are in charge of several patients. But each family is looking after a single patient. Therefore, doctors believe, that families are in a better position of doing truth-telling. They think that truth-telling can be done better in a stepwise manner and with more time. This, in turn, helps doctors to spend less time on each patient and leave the responsibility of truth-telling to patients’ families.

As families are entrusted with the choice and responsibility of communicating with the patients, doctors often times practice vague truth-telling to patients. In the following excerpt, a patient was indirectly informed about his terminal condition:

PG to the patient: “Are you aware of the disease? It has again come back. A gynecologist needs to be consulted for conducting the operation. If the surgery is not possible then chemotherapy is to be given. But only chemo cannot fully recover the patient, it will control the symptom and bleeding, without operation it is difficult to reduce the disease altogether.”

Here, the PG said that full recovery is not possible, and chemo will be given for symptom management. While this information is true it does not clearly confirm that the condition of the patient is terminal. This is because the phrase “chemo cannot fully recover the patient” can be subject to different interpretations. This phrase does not clearly state that the patient is terminal. It only says that the patient cannot go back to the stage of complete cure which does not mean the patient is incurable. This type of truth-telling helps doctors to hide crucial information even by remaining honest. This also helps them to transfer to the family the responsibility of delivering bad news to patients and saves them from investing time in emotion management. Doctors do tell families more clearly about the condition of the disease but even then, they may retain certain elements of vagueness as can be seen from the following words that a doctor said to a family member: “The patient’s health has further deteriorated because of you guys (family members) . . . if brought before, she would have recovered.” Although in this situation the doctor has hinted that the patient may not recover, but still he did not clearly say that the condition is terminal.

Doctors often approach truth-telling in a vague manner to families as well. If the doctors’ anticipate that truth-telling can lead to an emotional breakdown of families which in turn will require doctors’ to perform emotion management to patient families’, doctors will perform vague truth-telling to families as well. Instead of clearly telling them about the patient’s terminal condition, they reply in a manner which can be interpreted in more than one way. For example, one doctor told me “we tell the families that the condition of the patient is not good, that the disease has spread etc., in this situation we do not say that you will be completely cured, but we say that let’s see how far we can do about it and what steps will make it better, so that you stay well.” However, doctors are aware of the workload and time constraints. During an interview, a doctor confessed about time constraints, “Before breaking the bad news to a patient, the amount of time that is required for the emotional or psychological counseling, I cannot provide that time to the patient.”

False hope helps doctors to avoid breaking the bad news to patients thus increasing work efficiency. One reason doctors are able to give false hope is that they are often backed by family members of patients to do so. Family members believe that giving false hope is the right approach when communicating with terminal patients. Even when family members tell patients that they have cancer they rarely communicate about the terminal condition of their health.

The son of a patient informs her about the treatment updates but even then, does not disclose that the patient is palliative:

Son of the patient: “At first we did not tell her but now she knows. She is quite aged might expire soon. I just say, “just be strong, you will recover.” Whatever test they are asking us to do we are keeping mother informed about it so that even patient is prepared mentally.”

Me: “So, you did not tell her that she won’t get cured?”

Son: “That cannot be said.”

Here, initially, the family did not want to tell the patient much about the illness. Later on, reluctantly they shared some information with the patient, as her condition was deteriorating, coupled with more treatments which made it harder to hide. But even then, the news that the condition of the illness was terminal was not shared with the patient.

One doctor informed me that "...the families insist on not telling the truth. Sometimes the patient party comes to us and whispers in our ears- 'please don't tell the truth'." In that case, we have to give that patient a false hope..." Doctors also believe that it is better to give false hope only to uneducated patients: "I think for the educated person it is bad, but for the uneducated persons it is okay if they spend the last few days of their life with false hope. Ignorance is bliss."

Doctors think that most times it is better not to go for honest truth-telling as this leads to patient dropouts. Given that patients often stop coming because of economic and other issues, doctors take this dropout into consideration when doing truth-telling. During interviewing one doctor told his views:

This is my personal opinion that in Indian society or the present society of South Pradesh (the state where I did my fieldwork), I think it is better to withhold information. For example, there is a Kumar Medical Centre in Mangpur (the city where I did my fieldwork), it is a corporate hospital under Kumar. What they do is, on the very first day they clearly disclose the entire prognosis to the patients. As a result, many patients leave the hospital and they say that "we won't do our treatment there." When asked "Why? They (patients) say, "because they (doctors) told me on my face that I will live for six months only. But I do not feel any discomfort, I am fine. Then why did they say like this? If they say these things, I will lose all courage and how will I fight against it?" So, then we give the patients a false assurance that yes you will get better. But we tell the family that whatever they had said was true. We give false support to the patient that, no you will recover which the patient accepts. So, as they (Kumar Medical Centre) disclose the prognosis to the patients, many of them come to us. So, I think that as a whole, we are not that much advanced to hear the exact prognosis. (interview transcript)<sup>3</sup>

The doctor argues that truth-telling leads patients to think that the doctors are not capable enough to cure their illness. They may completely discontinue treatment (if they feel hopeless) or switch to other doctors. This doctor believes that only in more educated and advanced societies, honest truth-telling can be successfully practiced.

## Discussion

Using false hope not only helps patients to cope but also increases the work efficiency of Indian doctors. Past studies have argued that certain cultures welcome the practice of giving false hope. Truth-telling is seen as cruel as it robs dying patients of their hope and can cause psychological damage to the patients. In India families back doctors giving false hope, and doctors leave the extent and responsibility of truth-telling to families. This saves doctors time, as patients require less emotion management if they believe that they are curable. False hope works the dual role of efficiency (of doctors) and coping (of patients). Few studies that have examined false hope in the past, focused primarily on the psychological consequences of false hope. Here, I add to the literature by arguing that false hope has an organizational impact as it can be effectively used to improve work efficiency.

There are multiple reasons why the culture of false hope is successfully implemented in the hospital. Most of the patients in the hospital are uneducated. As a result, it is easier for doctors to hide information from patients. The medical reports and prescriptions are written in

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<sup>3</sup> The names of the city, state and hospitals are changed to maintain confidentiality.

English and contain many technical terms. As a result, it is very hard for patients who cannot read English to understand the meanings of the prescriptions. Additionally, family members at times request doctors not to do truth-telling in front of patients. Moreover, doctors are themselves in favor of giving false hope as it increases their work efficiency. However, as discussed earlier, doctors believe that the practice of false hope should not be done with educated patients. Future studies need to examine truth-telling in private hospitals where patients belong to higher socioeconomic backgrounds.

One may argue that false hope is detrimental to work efficiency. If honest truth-telling leads to patient dropouts, then false hope leads to retaining more patient which increases workload thereby reducing efficiency. In reality, doctors are reluctant to increase work efficiency at the expense of demoralizing patients to the point of them not coming to doctors. In fact, the motivation of doctors behind minimizing emotion management to each patient is to have enough time to give medical treatments to all the patients. However, as the doctors are paid a fixed governmental salary economic benefits are not the incentive behind patient retention. Empathy for the poor, terminal patients may be the driving force for these doctors to retain the existing patients. Future studies need to look at the relationship between empathy and efficiency in more details.

A surprising finding of the present study was the role of anger in palliative care settings. Kübler-Ross (1969) first claimed that patients may feel anger at impending death. However, here, we find that the doctors express anger to patients who are close to death. Expression of anger actually helps the doctors to work efficiently when the patient load is high. This is because patients stop inquiring when facing an angry doctor. In very rare situations, patients in India express anger. As anger can slow down work efficiency, doctors manage the emotions of patients in those situations. Use of humor helps the doctors to manage the anger of patients as well as coworkers.

The question arises why Indian patients are reluctant to express anger in palliative care. One of the reasons may be is that most of the patients are not aware of the non-curable status of their disease (as doctors give false hope to patients) and therefore, do not strongly feel anger (unlike the terminally ill patients observed by Kübler-Ross 1969). In addition, given that patients have limited financial resources, dependency on doctors for morphine and other treatment facilities, and their lack of education and knowledge about cancer, patients have considerably lower power than the doctors. This lack of power inhibits patients to express anger in front of doctors. Not only do patients avoid expressing anger in front of doctors, but they also try to manage doctors' anger as an upset doctor can be seen as a threat to treatment.

The study also has ethical implications; it raises a debate on how truth-telling can be best practiced across societies. Glaser and Strauss (1965: 126) argued: "simply to disclose in the hope that the patient will be able to prepare himself for death is just as unguided and as ad hoc as to not disclose because he may commit suicide." The "tendency to individualize, personalize, and privatize decisions is a quintessentially Western phenomenon" (Anspach 1993: 165). By studying the interactions between the health care providers and the seekers, I analyzed the interactions in the context of truth-telling and emotion management in an Indian setting. Such knowledge, in turn, raises the question whether the current western notion of information sharing between the doctor and the patient should be the model method of a moral society contributing to the debate whether the patients also have a right not to know.

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