Philosophical Medical Ethics

Telling the truth and medical ethics

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In this series I have discussed four principles for guiding action that seem to be required by any adequate philosophical theory of medical ethics: a principle of respect for persons, notably for their autonomy; a principle of beneficence; a principle of non-maleficence; and a principle of justice. Much moral debate stems either from disagreement about scope (about what sorts of entity are owed what sorts of moral concern) or from disagreement about the relative importance of these four principles. In the next four articles I shall look at examples of conflicts in the context of medical ethics that are primarily between the principle of respect for autonomy on one hand and the principles of beneficence and non-maleficence on the other. I shall start with the issue of telling the truth.

Telling the truth

"In much wisdom is much grief: and he that increaseth knowledge increaseth sorrow"—(Ecclesiastes i, 18). Thus Dr Maurice Davidson began his chapter on truth telling in his 1957 book on medical ethics.¹ Davidson, however, argued against the tendency of "so many medical practitioners to withhold the facts from their patients, especially in cases of grave illness, and to insist that the truth must at all costs be kept from them." Rejecting this as a "fetich," which was wholly unjustifiable, he argued that real harm rarely resulted from honesty in response to patients who wanted reliable information about their condition. They might have "vitaly important duties" that they could carry out only if they were given such information, and failure to divulge the plain facts was in the long run "a frequent cause of the greatest distress." As Davidson freely admitted, he was unusual among doctors in holding these views, but he remained unconvinced that the arguments of his colleagues against such frankness were "anything but an excuse for evading what is admittedly an extremely unpleasant duty."

Sympathetic as I am to Davidson's position, I think the opposing position needs more consideration. The case for deception in medical practice, whether in the context of fatal or grave disease or in informing patients of the risks of treatment or research, is usually based on three major arguments (elegantly dissected, among many others, by the philosopher Sissela Bok in her book *Lying*).

The case for deception

The first argument in favour of deception is, as indicated above, that doctors' Hippocratic obligations to benefit and not harm their patients override any requirement of not deceiving people. For example, by definition patients with serious illness already have severe problems; the doctor adds to these problems by giving patients distressing news; moreover, patients' prospects of recovery often depend crucially on their morale and perhaps on some element of placebo effect or, in Balint's memorable phrase, "the drug

doctor," or both. Passing on unpleasant medical information will probably undermine these and thus impair patients' prospects of recovery.

The second argument in favour of not telling the truth is that it cannot be communicated, both because a doctor is rarely, or never, in a position to know the truth (he can never be sure of the diagnosis or prognosis) and because even if he were the patient would rarely, if ever, be in a position to understand it. Even common words such as "cancer" are likely to be radically misunderstood by patients unless they have had a medical training. The wide range of conditions and prognoses and all other technical nuances implied by the word are probably not taken into consideration and are often replaced by a single dark understanding that cancer is simply another word for a peculiarly horrible death. As an American doctor emphatically summarised this argument, "It is meaningless to speak of telling the truth, the whole truth and nothing but the truth to a patient. It is meaningless because it is impossible" (he went on to recommend the "far older" medicomoral guide, "So far as possible do no harm").³

The third common medical argument against telling the truth is that patients do not wish to be told the truth when it is dire, particularly when they have a dangerous or fatal condition.

Precedence of beneficence and non-maleficence

With regard to the first argument—that the principles of beneficence and non-maleficence must take precedence over any requirement of not deceiving people—I showed in my article on autonomy how even for utilitarians (for whom the overriding moral principle is to maximise welfare and minimise harm) the principle of respect for autonomy is a crucial moral principle, while for Kantians respect for people and their autonomy is itself the overriding moral principle.

As deceiving people in medical contexts usually means failing to respect their autonomy (usually in each of the categories I outlined: thought, intention, and action) by denying them adequate information for rational deliberation, even from a utilitarian viewpoint it is probably morally unacceptable unless there is strong reason to believe that in a particular case overall welfare would be maximised by deception. Furthermore, the various arguments adduced in my discussion of medical paternalism apply to this specific example: not only can welfare be expected to be increased by honesty and frankness but also there is no reason to assume that doctors are particularly skilled judges of what course of action maximises welfare. Generally, so far as the welfare of individual patients is concerned they themselves are probably the best judges of whether knowing the truth about unpleasant facts will or will not improve their welfare.

There is, of course, an important practical difficulty here: how is the doctor to find out a patient's views without disclosing any unpleasant facts to those patients who would rather not know such information? There is no simple answer to this, but by sensitive questioning or by simply (but genuinely and at different times) offering to answer any questions, and giving adequate time for this, skilful doctors can often master this difficult medical art. In this

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context the remarkable psychological defence mechanism of denial may be reassuring; even after being told of their impending demise many patients seem to eliminate this information from their minds and deny that they have been given it, and, according to Kubler Ross, most people who know they are fatally ill tend to move in and out of such denial, more so to start with than later on.⁴ Perhaps denial is a natural defence against being overburdened with such difficult thoughts when people are unable to cope with them. In addition to skilful and sympathetic discussion with patients after unpleasant information has been discovered, pilot studies could be run to find out the pros and cons of asking patients in advance their views on being deceived about unpleasant news, and indeed on a whole range of other medicomoral issues—an upgraded version of asking them what religion they espouse. For example, when they first registered with a doctor or attended a hospital patients could be offered an opportunity to answer a questionnaire about such matters, including how much they would like to participate in decision making or how much they would prefer to leave it to medical people; how much they would want to be told any bad news or how much they would wish to be shielded from it; whether or not they would wish to donate their organs if they died; whom they would allow to be told about their medical condition and whom not; which matters, if any, they considered to be particularly sensitive; and so on?

It astonishes me how, with a few exceptions, whenever I suggest this idea to medical colleagues there is widespread scorn—for example, “You’ll terrify them,” “What they say when they are fairly well couldn’t be relied on when they are ill,” “They might have changed their minds,” “Suppose they have not understood the questions,”—yet when I suggest it to non-medical people the idea is usually embraced enthusiastically and the counterarguments rejected—“It might be worrying but at least the doctors would know what you wanted,” “One wouldn’t say something important unless one felt fairly sure about it,” “Why shouldn’t they design the questionnaire so that you did understand it?”

At the very least, it seems worth investigating such a scheme on a pilot basis to see if it offers any advantages in patient care and to find out what the problems are. Such an investigation would surely be as worthwhile for an MD thesis as many a more technical topic.

Impossibility of communicating the truth

The second argument against telling the truth concerns a fundamental confusion between the moral issue of truth telling and truthfulness on one hand and the epistemological, logical, and semantic problems that beset the concept of truth itself. Although these last three issues are of central importance in philosophy, they have little to do with the question of what it is right to do with such knowledge of the truth as a person believes himself to have. Here, the crucial moral issue concerns the doctor’s intentions—in particular, does he intend to discover what the patient would wish to know and does he intend to try to meet such wishes when they concern the transmission of information that the doctor believes to be both true and likely to distress the patient, or does he intend to deceive the patient? Of course, most medical information is typically probabilistic, of course, patients will vary in their ability to understand complex medical information, of course, “the whole truth” is usually a mirage, and, of course, even philosophers disagree about what is meant by “truth.” In the ordinary case none of these difficulties are relevant to the moral dilemmas of truthfulness and deceit. Those with residual doubts should, as Sissela Bok suggests,² imagine what their response would be to a used car dealer who used such arguments to justify his deceit.

Patients’ wish not to know

Finally, there is the argument that patients do not want to be told the truth about their fatal condition. This is an important argument as it implicitly acknowledges that doctors ought to respect their patients’ wishes. Several surveys have, however, shown that most patients surveyed (usually over 80%) would like to be told the

truth.^{5,9} On the other hand, until fairly recently most American doctors surveyed generally withheld the truth about diagnoses of cancer from their patients,¹⁰ though recently this has changed radically, with up to 97% of responding doctors preferring to tell patients with cancer their diagnosis.¹¹ Again this is an empirical question, but if the premise on which it is based is accepted—notably the desirability of doing what the patient wants—then the important issue is not what most patients or doctors think but what the particular patient in the particular circumstances wants. There seems to be no real doubt that the third argument is false and that at least some, possibly many, patients would wish to be dealt with honestly.

It should be emphasised that the forgoing counterarguments do not support indiscriminate, casual, curt, or unsupportive truth telling to all patients, approaches that are alas not unknown in medical practice, as Goldie disconcertingly recounts.¹² Nor do they deny the considerable difficulties concerned. They do reiterate that avoiding deceit is a basic moral norm, defensible from several moral perspectives, including those primarily concerned with maximising welfare, provided that welfare is not assessed simplistically on the basis of mere consideration of a patient’s immediate distress on being told dire news.

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This and subsequent articles continue the series by Dr Gillon started earlier this year.

A couple in their 40s have asked whether a test tube pregnancy in which they can use the husband’s sperm would be possible. His semen count is adequate but he has immobile sperm. Investigations show her to be fertile.

The first problem is the wife’s age. The chance of successful in vitro fertilisation falls in women over 40 and there is a high rate of miscarriage.¹ Because of this in vitro fertilisation programmes are often reluctant to admit women in their 40s.² The second problem is the immobility of the husband’s sperm. Male infertility may be an indication for in vitro fertilisation, but of the factors assessed in semen analysis, low progressive motility particularly impairs the chance of success.³ One Australian centre has reported that fertilisation rates are reduced when there are fewer than 5 million motile sperm/ml.⁴ According to a recent report from Cambridge, a combination of a low sperm count and poor motility causes the greatest problems,³ but careful preparation of spermatozoa by sedimentation and layering methods can improve sperm motility and raise the chance of fertilisation: almost 50% of men with fewer than 500 000 motile sperm/ml were successful in establishing pregnancy.—JAMES OWEN DRIFE, senior lecturer in obstetrics and gynaecology, Leicester.

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