Honesty in Medicine: Should Doctors Tell the Truth?

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Introduction

Should physicians not tell the truth to patients in order to relieve their fears and anxieties? This may seem simple but really it is a hard question. Not telling the truth may take many forms, has many purposes, and leads to many different consequences. Questions about truth and untruth in fact pervade all human communication. They are raised in families, clubs, work places, churches, and certainly in the doctor/patient relationship. In each context, the questions are somewhat differently configured.

Not telling the truth in the doctor-patient relationship requires special attention because patients today, more than ever, experience serious harm if they are lied to. Not only is patient autonomy undermined but patients who are not told the truth about an intervention experience a loss of that all important trust which is required for healing. Honesty matters to patients. They need it because they are ill, vulnerable, and burdened with pressing questions, which require truthful answers.

Honesty also matters to the doctor and other medical professionals. The loss of reputation for honesty in medical practice means the end of medicine as a profession. Important as it is for patients and doctors, however, honesty has been neither a major concern in medical ethics nor an important value for doctors. It may be an exaggeration to say that honesty is neither taught in medical school nor valued in medical culture, but it is not too much of an exaggeration.

Is concern for honesty and truth telling as absent or as threatened in other professions? Is honesty a respected virtue among lawyers? The very question will appear ridiculous to most people. Is truth any more respected by brokers, politicians, policemen? All these so called professionals are publicly committed to do what is best for others and yet the others frequently are not told the truth. Could doctors actually have fallen in with lawyers and brokers and politicians in undermining the foundations of what we have known for centuries as the fiduciary role in a true professional? If so, the loss to medicine is tragic because there is no comparison between the consequences of lying in the doctor-patient relationship and the lying that goes on elsewhere. Besides harming a patient's autonomy, patients themselves are harmed, and so are the doctors, the medical profession, and the whole society, which depends on humane and trustworthy medicine.

Inattention to truth or violations of honesty by medical personnel is serious business. There is a lot at stake as well for nurses, researchers and other health professionals. The truth issue is worth thinking about by all health-care professionals. In some cases the harm from not telling the truth may be less. Some degree of dishonesty may even be excusable sometimes in order to avoid more serious patient harm. If there are reasons for not telling the truth, what are they? When could incomplete disclosure be justified and under what circumstances? What exceptions, if any, exist to
the rule against lying? What kind of arguments support the answers to these questions? These are
the issues we will be trying to sort out.

**Truthful Disclosure vs. Lying in a Clinical Context**

Subtleties about truth telling are embedded in complex clinical contexts. The complexities of modern medicine are such that honesty or truth, in the sense of simply telling another person what one believes, is an oversimplification. There are limits to what a doctor or nurse can disclose. Doctors and nurses have duties to others besides their patients; their professions, public health law, science, to mention just a few. They also have obligations created by institutional policies, contractual arrangements, and their own family commitments. The many moral obligations a nurse or physician may have to persons and groups other than to the patient complicates the question of just how much a professional should disclose to his or her patients.

Doctors and nurses in some cultures believe that it is not wrong to lie about a bad diagnosis or prognosis. Certainly this is a difficult truth to tell but on balance, there are many benefits to telling the truth and many reasons not to tell a lie. Tolstoy gave us a powerful message about the harms, which follow from lying to dying patients in The Death of Ivan Illich, and his insights came out of a culture which assumed that lying was the right thing to do in such circumstances.

Listen-"This deception tortured him--their not wishing to admit what they all knew and what he knew, but wanting to lie to him concerning his terrible condition, and wishing and forcing him to participate in that lie. Those lies--lies enacted over him on the eve of his death and destined to degrade this awful, solemn act to the level of their visitings, their curtains, their sturgeon for dinner--were a terrible agony for Ivan Ilych"

Determining the appropriateness of less than full disclosure is one thing, but trying to justify a blatant lie is another thing entirely. Lying and deception in the clinical context is just as bad as continued aggressive interventions to the end. Both qualify as torture.

Sigmund Freud paid more attention to the subtleties of the doctor/patient relationship than almost any other physician. He saw the damage which lying does to the doctor, to the therapeutic relationship, and to the medical profession. Since we demand strict truthfulness from our patients, we jeopardize our whole authority if we let ourselves be caught by them in a departure from the truth.

Lying in a clinical context is wrong for many reasons but less than full disclosure may be morally justifiable. If a patient is depressed and irrational and suicidal, then caution is required lest full disclosure contribute to grave harm. If a patient is overly pessimistic, disclosure of negative possibilities may actually contribute to actualizing these very possibilities.

Now that so many medical interventions are available it is obviously wrong not to disclose the truth to a patient when the motive is to justify continued intervention or in order to cover up for one's own failures for your benefit, not the benefit of the patient. Doctors and nurses, however, can
do as much harm by cold and crude truth-telling as they can by cold and cruel withholding of the truth. To tell the truth in the clinical context requires compassion, intelligence, sensitivity, and a commitment to staying with the patient after the truth has been revealed.

If a patient is in a high-tech tertiary care facility, the problem of deciding just what to disclose is compounded by the difficulty of deciding the right person to make the disclosure. A patient can be attended by any number of professional staff members, each of whom has a professional code and some sense of responsibility for telling the truth. Traditionally, the doctor alone was responsible for all communication. Today, social workers and nurses also claim responsibility for truthful communication with patients and families. Since all employees of a health care institution are bound by institutional policies (including a Patient's Bill of Rights), coordination of truth-telling is also more of a problem. One staff person who is not truthful is likely to be exposed by another.

**Truth Telling and Patient Autonomy**

A professional obligation to be truthful does not need linkage with patient autonomy to be justified but in fact it is often so joined. Then, it tends to require what autonomists refer to as full disclosure. For them, it is not sufficient to tell the truth, one has to tell the whole truth. Radical advocates of patient autonomy tend to eliminate physician or nurse discretion and simply require that "everything be revealed" because "only the patient can determine what is appropriate." Other principles, like beneficence, non-maleficence, and confidentiality, may be given little consideration or turned into subordinate obligations.

Autonomists who insist always on full disclosure usually set aside questions about uncertainties, which permeate the clinical context. But, medical diagnoses and follow-up therapeutic regimens are rarely a matter of mathematical certainty. Psychiatric diagnoses for example, like diagnoses in many other specialties, develop from hypotheses that are then tested out through continuing symptom evaluation and carefully watched responses to therapeutic interventions. Does every feasible hypothesis require disclosure to a patient? Is every bit of data about a disease or therapy to be considered information to be disclosed?

Generally speaking, relative certainties and realistic uncertainties belong within honest disclosure requirements because they qualify as information that a reasonable person needs to know in order to make right health-care decisions. But reasonable persons do not want full disclosure even if such were feasible. Telling the truth in a clinical context is an ethical obligation but determining just what constitutes the truth remains a clinical judgment. Autonomy cannot be the only principle involved. Truth telling has to be linked with beneficence and justice and protection of the community.

**Clinical Context and Clinical Judgment**

We can see the clinical context's influence on truthful disclosure when we look at an emerging new field like genetic medicine. What truth should be communicated to a patient who has just undergone a diagnostic test that indicates a possibility that the patient will develop an incurable
disease? Should the simple facts be disclosed? How? When? By whom? To whom? After what kind of broader patient assessment? What if the patient has a history of suicidal tendencies?

If a genetic test reveals predisposition to certain diseases, who interprets predisposition or increased risk? What should be disclosed to a worrisome patient? If a genetic test indicates that a certain disease at some point will be expressed, for which there is no cure or therapy, should the eventual disease manifestation simply be disclosed? The patient may die from another cause before the genetically potential disease appears. If genetic tests suggest that a woman age 40 has a 20% chance of cancer, which increases as she ages, when should the information be disclosed? All these questions make one simple but important point; that disclosure of the truth in a clinical context requires a clinical judgment and is not a matter of simply stating what is factually or scientifically true or telling everything and letting the patient decide.

New York hospitals have just altered an institutional ethic policy on truthful disclosure about H.I.V. status to a new mother. Previously H.I.V. testing and disclosure of test information required patient permission. Now both are automatic. The shift reflects a re-evaluation of the risks and benefits associated with H.I.V. testing and the possibility of altering the course of the disease in adults who know the truth about their status. Now truth, in the sense of reporting known factual information, is considered a public health responsibility and more important than a patient's right to control or to individual autonomy. This is another example of a changing medical context and delicate clinical judgment about disclosure of truth.

The concept of clinical context can extend over to the financial dimensions of medical practice. Lawyers, driven by self-interests, have permeated the clinical context with the fear of malpractice suits and this situation makes revealing mistakes and errors imprudent or even self-destructive. Ideally, truthful disclosure of physician or hospital errors to patients would be recommended and would likely strengthen the trust between doctor and patient, but this is rarely the case in today's clinical context. Here a conflict may exist between prudence and truthful disclosure and no simple rule, like tell everything, will resolve the conflict.

**Justifying Less Than Full Disclosure**

Withholding information from a patient does not always undermine veracity or violate the truth principle. Sometimes patients request that information be withheld. Doctors sometimes are asked to make decisions for patients without communicating relevant information. Ordinarily, respecting such requests violates no major ethical principle: neither autonomy, nor truth, nor beneficence. But clinical judgment is always required because in some cases, even a reluctant and intimidated patient who requests not to be informed, needs to know some truths. Not knowing may create a serious danger to self or to others, and if so, the patient's request that information be withheld cannot be respected because it violates the core principles of beneficence and nonmaleficence.

Certain traditional cultures see the patient not as an autonomous entity with inviolable rights but as part of an extended family unit. Family members rather than the patient are given medical information, especially threatening information like a fatal diagnosis. Medical ethics requires
respect for cultural practices because these are closely related to respect for individual patients. And yet, cultures change, and families are different, and some cultural practices are ethically indefensible. Clinical judgment may require that a patient be included in the information cycle rather than cooperating with a cultural practice, which prefers painful isolation and communication only with the family.

Sometimes, a particular family member may be the designated decision-maker for an incompetent patient who later regains competency. Then who gets what information? Ordinarily both family and patient can be kept informed and will agree about options, but not always. Again, the clinician has to make a judgment not only about patient competency but about what information the patient can handle and when the family should take charge. If family members give a doctor or nurse important medical information not known to the patient, ordinarily they would be told that professional medical ethics requires that a patient be given such information. However, as with other contextual variations, great sensitivity and subtle clinical judgment is required.

**The Dying Patient**

No one could pretend to speak for every patient in every context but generally speaking, patients want to know the truth about their condition and doctors are unlikely to be correct when they judge this not to be the case. Some patients who are given a cancer diagnosis and a prognosis of death may use denial for a while and the bad news may have to be repeated, but the use of denial as a coping device does not mean that patients would prefer to be lied to or that truth is not important to them. Patients need the truth even when it tells them about their death. To live without confronting the inevitability of death is not to live in anything approaching a rational or moral way. It is wrong to assume that patients prefer irrationality and moral superficiality. A death notice is a shock and a pain and yet patients can derive benefit from being told the truth even about their own death.

Without the disclosure of truth in a dying situation, patients are likely to be subjected to aggressive treatments which will turn their dying into a painful, expensive and dehumanizing process. It is just this kind of situation that has contributed to increasing support for the euthanasia movement. Patients rightfully are afraid that they will not be told the truth about their medical condition and therefore will die only after futile interventions, protracted suffering, and dehumanizing isolation. On the other hand, the benefits of being told the truth may be substantial; for example, improved pain management, even improved responses to therapy, etc.

But harm too may come from telling the truth about death. Harm may be rare, but still it must be guarded against. The doctor who tells a dreadful truth must do so at a certain time, and in a certain way. The communication of truth always involves a clinical judgment. Truth telling in every clinical context must be sensitive and take into consideration the patient's personality and clinical history. Generally speaking, however, in case of doubt it is better to tell a patient the truth.

In complex clinical contexts, it may be difficult to draw the line between truthful disclosure and a violation of truth. Reasons could certainly be advanced to justify not telling a certain patient the
whole truth. Outright lies, on the other hand, rarely are excusable. Something less than full and complete truth is almost inevitable. The good clinician is not just good at medicine and a decent person; he or she is also good at judging just what the principle of truth telling requires in a particular clinical context.

**Truth In the History of Medical Ethics**

The historical medical codes addressed issues like not doing harm, not taking life, not engaging in sexual acts, not revealing secrets, but said little or nothing about telling the truth and avoiding lies. The value of not doing harm was so strong that lying in order to avoid harm was considered acceptable, a twisted form of medical virtue. Because communicating the truth about disease is difficult, many physicians simply discounted or ignored the moral problem of truthfulness in the doctor-patient relationship. The importance of not doing harm in effect relegated truth telling to the category of "everything else being equal, tell the truth" or "tell the truth as long as it helps rather than harms the patient."

Because of the historical centrality of nonmaleficence, and because telling the truth about fatal or even serious diagnoses was assumed to cause harm to the patient, physicians traditionally did not tell the truth to patients. Many moral philosophers referred to physician discourse with patients as an exception to the obligation to tell the truth. The doctor's principal moral obligation was to help and not to harm the patient and consequently, whatever the doctor said to the patient was judged by its effect on these core duties.

Today, things have changed. Beneficence and non-malifcience remain basic medical ethical principles, but truth is also a medical ethical principle. The importance of truth telling in the clinical context derives from taking more seriously the patient's perspective in medical ethics. The historical justifications of lying to patients articulate the perspective of the liar, not that of a person being lied to. In most cases people are hurt when they are deliberately deceived. This is especially true of patients. This may not have been so historically, but it is definitely true today. Today, Bacon's comment that "knowledge is power but honesty is authority," is particularly applicable to doctors. In the end, lies in the doctor/patient relationship hurt patients, doctors, the medical profession, and the whole society, which depends upon a medical system in which patients can trust a doctor's authority.

The historical absence of a truth requirement in medical ethics has much to do with the moral assumptions of ancient cultures. Paternalism in our culture is a bad word, a "disvalue," something to be avoided. In earlier cultures it was an ideal to treat other persons as a father treats a child. Paternalism was something virtuous; the opposite was to treat the other as a slave. In early Greek culture, the good doctor or the good ruler treated the patient or the citizen as a son or daughter rather than a slave. He did what was best for the "child" but without ever asking for his or her consent. With no involvement in treatment decisions, making known the truth to a patient was less important. Because patients today can and must consent to whatever is done to them, truthful disclosure of relevant information is a legal and ethical duty.
Modern medical ethical codes reflect this shift in the importance of veracity. The code of the American Nurses Association states: "Clients have a moral right to be given accurate information." It urges nurses to avoid false claims and deception. Even the "Principles of Medical Ethics" of the American Medical Association, in 1980, included a reference to honesty. "A physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception." This first official reference to veracity in physician codes remains a very abstract one, and is more concerned with failures of honesty among colleagues than with truth telling to patients.

The American College of Physicians however did refer to the physician's obligation to honesty in the doctor/patient relationships in its ethics manual. It focused on the obligation to provide truthful information to patients in order to contribute to an acceptable doctor/patient relationship. Similar references and recommendations have been included in sub-specialty medical codes (orthopedics', surgeons', psychiatrists', obstetricians' and gynecologists').

The link between patient autonomy and veracity is characteristic of modern medical ethics and is most evident in the American Hospital Association's "Patient's Bill of Right" (1972). The requirement of honesty is clearly linked today with the patient's new legal right to give informed and free consent or refusal of treatment. Patient power in the doctor/patient relationship is the distinguishing element of modern medical ethics. In requiring adequate information for decision-making, modern medical ethics broke with the paternalistic tradition. Traditionally the doctor did not tell the truth lest the patient be harmed. Now, not to harm the patient requires in most instances that patients be truthfully informed and then invited to participate in clinical decision-making.

If today a physician decides, in light of clinical considerations, to conceal the truth, he or she must bear the burden of proof. A doctor must be able to defend this decision before other professional persons involved in the patient's care. And some member or members of the patient's moral community must be given the truth. If physicians habitually lie, or conceal truth from patients, they cannot be excused based on a clinical context or a discrete clinical judgment.

**Truth and True Professionals**

If providing truthful information to a patient is a matter of judgment, mistakes are bound to be made. If the information itself is limited and the amount to be disclosed must be determined by the context of each case, then inevitably there will be inadequacies and failures. It is one thing to fail, to make a mistake, to miscalculate what should have been said. It is quite another thing, to set out to lie. It is even worse to adopt a pattern of deception. Failure is one thing, becoming a liar is quite different, something incompatible with being a professional.

For a true professional, striving to become an honest person is important. We have seen the strong stand of Immanuel Kant on this issue. Now listen to the person against whom Kant was most often pitted against and with whom he most often disagreed, John Stuart Mill. In the following quote, he is talking about the feeling of truthfulness or veracity. He said that his feeling is
"one of the most useful, and the enfeeblement of that feeling one of the must hurtful, things to which our conduct can be instrumental; and (..) any, even unintentional, deviation from truth does that much toward weakening the truth-worthiness of human assertion, which is not only the principal of all present social well-being but the insufficiency of which does more than any one thing that can be named to keep back civilization, virtue, everything on which human happiness on the largest scale depends."

For Mill, if someone as much as diminishes reliance on another persons' truthfulness, he or she is that person's enemy. Why? Because to lose the trust of others is to lose one's own integrity. A doctor can do even greater harm because not being honest damages the climate of trust within the profession. Then, it is not an individual's integrity, but a whole profession's integrity that is lost. If patients are habitually lied to or misinformed or deceived, then the context of medical practice is polluted. The whole profession is discredited.

A recent American movie, Liar Liar, attempted to make a comedy out of the all-pervasiveness of lying in the legal profession. The filmmakers seemed most interested in creating laughter but in the process made a not at all funny commentary on how lying and deceit have become pervasive among lawyers. Without lying, the main character could not function in the court system. His lawyer colleagues were repugnant characters. The comic star of the movie saved his life and his marriage and his moral integrity by discovering the importance of being truthful. Consequently, he had to seek a different type of work. The image of the legal profession portrayed in this film was sickening. We cannot let this happen to doctors and medical researchers.

Something similar must not happen to doctors and the medical profession. Now, more than ever, patients have to be able to trust their doctors and to be able to rely on the truth of what they are told. Since truthfulness and veracity are such critical medical virtues, doctors have to work to develop the virtue of truthfulness. This is not an easy task.

To become a truthful person we have to struggle first to know the truth. Then we have to struggle with personal prejudices which can distort any information we gather. We have to try to be objective. We have to, work to correct a corrupting tendency to confuse one side of a story or one perspective of an event with the whole truth. And, finally, we have to recognize that self-aggrandizement corrupts the capacity to know the truth and to communicate anything except pathological, narcissistic interests. Truth for an egoist is reduced to what promotes his ego. The egoist cannot see the truth and therefore cannot tell it. The only thing that can be communicated is his or her own aggrandized self.

Knowing the truth and telling the truth is difficult enough without shadowing weak human capacities for virtues with narcissistic pathological shades. If we are self-deceived we cannot hope to avoid deception in what we disclose. Not to address pathological character distortions is to make lies inevitable. The classical medical ethical codes were preoccupied with a good physician's personal character traits--rightfully so.
Conclusion

This paper argues for truth in the doctor/patient relationship but not for flat-footed or insensitive communication. The presumption is always for truth and against lying. But the arguments support the need to make humane clinical judgments about what is told, when, how, and how much. Perhaps the best way to sum up the argument is to quote a sensitive and humane physician on this topic: Dr. Cicely Saunders, the founder of the Hospice movement.

Every patient needs an explanation of his illness that will be understandable and convincing to him if he is to cooperate in his treatment or be relieved of the burden of unknown fears. This is true whether it is a question of giving a diagnosis in a hopeful situation or of confirming a poor prognosis.

The fact that a patient does not ask does not mean that he has no questions. One visit or talk is rarely enough. It is only by waiting and listening that we can gain an idea of what we should be saying. Silences and gaps are often more revealing than words as we try to learn what a patient is facing as he travels along the constantly changing journey of his illness and his thoughts about it.

So much of the communication will be without words or given indirectly. This is true of all real meetings with people but especially true with those who are facing, knowingly or not, difficult or threatening situations. It is also particularly true of the very ill.

The main argument against a policy of deliberate, invariable denial of unpleasant facts is that it makes such communication extremely difficult, if not impossible. Once the possibility of talking frankly with a patient has been admitted, it does not mean that this will always take place, but the whole atmosphere is changed. We are then free to wait quietly for clues from each patient, seeing them as individuals from whom we can expect intelligence, courage, and individual decisions. They will feel secure enough to give us these clues when they wish.

Finally, to tell the truth is not to deny hope. Hope and truth and even friendship and love are all part of an ethics of caring to the end.