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Telling the truth

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Author's abstract

Are doctors and nurses bound by just the same constraints as everyone else in regard to honesty? What, anyway, does honesty require? Telling no lies? Avoiding intentional deception by whatever means? From a utilitarian standpoint lying would seem to be on the same footing as other forms of intentional deception: yielding the same consequences. But utilitarianism fails to explain the wrongness of lying.

Doctors and nurses, like everyone else, have a prima facie *duty not to lie – but again like everyone else, they are not duty-bound to avoid intentional deception, lying apart; except where it would involve a breach of trust.*

Roger Higgs, in his thoughtful article, On telling patients the truth (1), raises the question whether honesty is as much a duty for doctors and nurses as it is for everyone else. He argues that lying is defensible in medical practice only at either end of the scale of importance: 'It may finally be decided that in a crisis there is no acceptable alternative, as when life is ebbing and truthfulness would bring certain disaster. Alternatively, the moral issue may appear so trivial as not to be worth considering (as, for example, when a doctor is called out at night by a patient who apologises by saying, "I hope you don't mind me calling you at this time, doctor", and the doctor replies, "No, not at all")' (2). But 'given the two ends of the spectrum of crisis and triviality, the vast middle range of communication', Higgs maintains, 'requires honesty' (3). Within the 'middle range' lack of candour does more harm than candour, Higgs maintains. But, to minimise the harm done through telling the truth, doctors and nurses must study *how* to tell it (at the right time, in the right way, and if the news is distressing, with proper follow-up).

All this is surely both sound good sense and important. But Roger Higgs also argues that there is no important difference between outright lying and other forms of intentional deception; 'that it does not matter morally whether a deception is achieved with an outright lie, or by an equivocation, evasion, by being "economical with the truth", or merely by refraining from correcting a misunderstanding'. Thus, he says: 'Surely it is the *intention* that is all important. We may be silent, tactful or reserved, but if we intend to deceive, what we are doing is tantamount to lying' (4). And later on, he observes: 'It is hard, but vital, to see one's own evasion, duplicity or equivocation for what it is, a lie' (5).

Yet in general it is obviously *not* the intention alone that counts: we may aim to improve our bank balance – by thrift or by theft: it surely matters which. And we should not confuse the virtue of plain speaking with the vice of breezy error. It is false, rather than frank, to say that an evasion is the same as a lie. (To be sure, someone who lies may pretend to himself he is guilty only of equivocation or evasion: that is quite another story. We need, of course, to see our behaviour for what it really is, but *also* not to confuse categories.) The assimilation of lying to other forms of intentional deception makes sense if one is adopting a utilitarian approach to the issue of truth-telling. Otherwise not, as I hope to show.

It should also be noted that if you share with Roger Higgs the view that doctors and nurses do not enjoy a general dispensation from the duty everyone else is under not to lie and if you also share his view that intentional deception is tantamount to lying, you must take a pretty dim view of the reputability of medical practice past and present. Has not benevolent deception always been part and parcel of accepted medical practice – 'he who cannot dissimulate cannot cure'(6)?

If doctors did think they had a special duty not to deceive intentionally we should expect it to get a mention in their codes and declarations. But it does not: not until 1980 (7) and then there is only the bland pronouncement that doctors should 'deal honestly' – no guidance is provided as to whether that means 'Tell no lies' or 'Don't hide the truth' or 'Tell all'. Current practice suggests that doctors do not interpret it as prohibiting benevolent deception.

Admittedly, many doctors past and present are sceptical about the therapeutic value of benevolent deception though perhaps none deny that there are

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some occasions when it is plainly in a patient's interests to be deceived. What these situations are and how common are not questions we need pursue here. We are addressing a prior question: whether the benevolent deception of a patient by his doctor is, like lying, generally contrary to duty. If it is, then the question whether or not benevolent deception is therapeutic in certain circumstances, though perhaps fascinating from the point of view of cause and effect, ceases to have any bearing on the question of right and wrong.

Here I hope to establish the importance of differentiating lying from intentional deception and to point up some of the practical implications for good medical practice of the differences to which I draw attention. My discussion is divided into three parts. In Part I, I distinguish lying from intentional deception. In Part II, I enquire how far everyone is obliged 1) to tell the truth and 2) to refrain from deliberate deception. In Part III, I enquire whether doctors are obliged 1) to tell the truth and 2) to refrain from deliberate deception when others, in general, are not.

Part I – some distinctions

DECEPTION IN GENERAL

A deceives B if and only if A causes B to be misled. My doctor's dour expression gives me the (false) impression that the symptoms which I am relating to him are sinister: I am misled.

Deceiving may be voluntary or involuntary. In the former case, my doctor maybe means to frighten me a little so that he can persuade me to adopt healthier habits. In the latter case, where his deception of me is involuntary, he is not putting on that expression for my benefit, still less to mislead me. He is perhaps simply following the advice of Securis that a doctor's 'countenance must be lyke one that is given to studye and sadde' (8) – advice which Securis offers to counter the risk run by the doctor who is always laughing, who is in danger of being 'taken for a lewde person' (9).

A sub-species of voluntary deception is:

Intentional deception: Voluntary deception is intentional if and only if A aims to mislead B: that is, if A acts as he does *in order* to mislead B. Perhaps my doctor's dour expression initially has nothing to do with me – it is directed not at me but at the clouds gathering outside the window. He is half-listening to me while fretting over whether it will be raining by the time the surgery ends and whether he will have to postpone his game of golf yet again. If he notices my misapprehension, recognises its cause, and does nothing to correct it then his deception of me which was initially involuntary becomes voluntary. If he does nothing to correct it because he realises how it might help him to bring me to my senses, then his deception of me becomes intentional as well as voluntary.

LYING

A lies to B if and only if A, in order to mislead B, informs B that something is the case although A believes that it is not the case. Lying is not a sub-species of intentional deception, on the account given above, since B need not be 'taken in' by A's lies. I ask my doctor, 'Have you been talking to my husband?' and he replies 'No' although he has and I already know it. I was just putting my doctor's honesty to the test. He lies to me but I am not deceived.

Whereas all liers intend to deceive not all who intentionally deceive tell lies. One way in which the discrepancy emerges is this – intentional deception like lying, does not require that A be communicating with B. Thus, for example if I, noticing that you are eavesdropping on my private conversation with someone else, say something false in order to mislead you, I am intentionally deceiving you but I am not lying to you. Intentional deception need not, of course, involve assertion of any kind.

Moreover, intentional deception, unlike lying, does not require that A believes what he imparts to B to be false. Suppose, for example, that B thinks that A is going to lie to him and suppose that A is aware of B's suspicion. A might proceed to tell B the truth in order to mislead B who will take what A says to be false. In this case A is not lying to B though plainly he is intentionally deceiving him. I am alarmed by my symptoms and suspect as I relate them to my doctor that he is going to play down their gravity to spare me anguish. My doctor, realising my suspicions, decides to take advantage of it to persuade me into adopting a healthier diet. Thus he proceeds truthfully to make light of my symptoms but he is at the same time intentionally deceiving me.

Notice that what we might call the conventional falsehoods of polite conversation, as in the exchange of greetings, are not lies by the above definition. Dennis Potter during a hospital stay overheard a nurse saying to a patient who was dying of throat cancer, 'How are you?' to which the patient managed to croak the reply 'In the pink': plainly a false assertion but hardly intended to deceive (10).

Part II – telling the truth as a general obligation

DOES EVERYONE HAVE A DUTY NOT TO TELL LIES?

Do people have a duty, at least a *prima facie* duty, not to tell lies – and if so, what is its source? To some people, the very notion of a moral duty or obligation might be problematic – they might wonder how there *could* be constraints on our conduct which are neither a mere matter of custom nor set up by some authority celestial or secular. Such misgivings should be respected. Necessities, moral or otherwise, must have an explanation – there must always be a reason *why* we must ... . But what kind of explanation we should be looking for in regard to 'moral' necessities and what counts as sufficient explanation are questions we cannot hope to dispose of adequately in a few incidental remarks.

One kind of explanation of the wrongness of lying, though, that is, I think, manifestly inadequate locates its wrongness in the harm suffered by those to whom

we lie: as if a person taken in by a lie is *ipso facto* harmed thereby. Suppose my doctor asks if I have taken my medicine and I lyingly reply that I have. The doctor wanted to know – but not for his own good: his remaining in ignorance does not damage him. Yet it is still the case that I have lied to him.

In seeking an explanation of the wrongness of lying we need rather to reflect on the necessity for any community to preserve trust and the crucial role upholding a rule against lying plays here. Just how strict a rule against lying it is necessary to uphold is not so easy to establish – although in view of the importance of preserving trust as the basis of fellowship and the extreme difficulty of restoring it in a community if once it is lost, it would seem that a pretty firm teaching is called for.

At least it would seem so if we can also assume that people would lie unless they were subjected to a firm teaching to check the tendency: only if we are prone to lie in the first place do we need to arm ourselves against the tendency with an appropriate teaching. Such an assumption about human nature might be challenged. Common sense, I suggest, endorses it despite the elementary familiar fact that simple prudence provides us with a natural restraint against lying (teachings aside): we do not want to risk being found out and forfeiting other people's trust. But we are not always prudent and anyway prudence does not always rule out lying. There are, I suggest, enough circumstances in which lying would appear to us an altogether convenient way to help our friends or hurt our enemies, to render a firm moral teaching against lying necessary. At any rate, if we are prepared to recognise any duties at all, we will surely include at least a *prima facie* duty not to tell lies.

DOES EVERYONE HAVE A DUTY NOT INTENTIONALLY TO DECEIVE?

In contrast to the case with lying the answer appears to be no. We all intentionally deceive one another daily without a second thought. Women wear make-up, men cover their incipient balding with strategic combings, we smile at each other's feeble witticisms even though we are not amused and we feign delight over gifts which fail to please. To be sure the fact that we all behave in a certain way without scruple is no proof that our behaviour is in fact innocent. But in this particular instance, I submit, there is no good reason to fault our behaviour. Are we not quite able to enjoy fellowship as a community despite a public tolerance of the many tricks of deceit we continually practise on one another, for example in casual conversation?

But when we enter a special relationship in which there is an understanding, explicit or implicit, between the parties the situation can change. The understanding may itself impose special duties and corresponding rights. Where such a special relationship exists, intentional deception in regard to certain matters may involve a betrayal of trust. Only then is it *prima facie* unjust. But B does not suffer such a betrayal unless 1) B has put trust in A and 2) B was entitled to do so.

Part III – telling the truth as a special obligation of doctors

WHEN IS LYING TO PATIENTS MORALLY DEFENSIBLE?

Even doctors who would defend lying as an acceptable feature of normal medical practice may agree with the rather feeble-sounding conclusion I have drawn in Part II, that everyone has at least a *prima facie* duty not to tell lies. They simply argue that often they are obliged to set aside this merely *prima facie* duty in order to fulfil their first duty as doctors – to care for their patients.

Two points deserve comment here. This defence of lying assumes (i) the patient's deception is often necessary (ii) where deception is justified, lying is justified.

(i) Is it true that doctors often have no alternative in fulfilling their caring duties – that deliberate deception is often therapeutically necessary? Perhaps doctors would want this question to be made more specific if it is to be sensibly discussed – is deception of child-patients or dying patients, or depressed patients often necessary? Be that as it may, the question does need to be made more specific in another way – in view of the inherent vagueness of the notion of necessity. A particular treatment, for example, may be said to be necessary in order to cure a patient – or to do so without enormous expense, or trouble, or distress to the patient. Thus, when it is said that lying is therapeutically necessary, we may need further clarification as to how, in what way, it is necessary.

There is, moreover, a lack of precision about a duty of care as opposed say to a duty not to commit adultery or a duty to pay one's debts. The duty of care is open-ended. There being virtually no end to what you can do in accordance with the duty of care it is far from clear what you must do in order to fulfil this duty. Legally, a doctor's duty of care is measured against the yardstick of normal practice. But morally?

In view of the vagueness about the notion of necessity and the imprecision about requirements imposed by a duty of care, we should not be surprised to find that doctors who agree that they have a duty not to lie and a duty of care may still disagree when presented with the same case history whether the one duty is overridden by the other.

Suppose, for example, that while doing a locum for a colleague away on holiday, you are called to attend a patient who is dying of cancer and whose relatives tell you that she does not know and must not be told: the truth, they insist, would kill her more swiftly than the disease. But what if when you meet her, she asks you point blank: 'Have I got cancer?' Could you be justified in lying?

In anticipation of finding yourself in such a situation let us suppose that you consult with some colleagues – they do not agree in their advice: Dr Noteller agrees with the relatives. He cites cases he has encountered in

which patients upon being told the truth have died with unexpected suddenness as if, indeed, the news precipitated their demise. Why risk that for patients whose diseases might otherwise allow them weeks, even months, of tolerable existence? Thus, does Dr Noteller counsel you to withhold the truth and, if necessary, lie rather than shatter the patient's hopes. Dr Teller disagrees with the relatives. He dismisses the tales of patients dying because allegedly 'they could not live with the truth'. This happens only where the doctors concerned botch the telling, he insists, and do not follow it up with proper counselling. It is not necessary to lie or even to deceive in such a case. On the contrary, the patient and the relatives should be told the truth so that they can be freed from the isolating trap of deception that makes dying an unnecessarily lonely experience for both parties. But the patient and the relatives need help and support to come to terms with reality. Thus does Dr Teller counsel you *not* to lie. Indeed he urges that the patient be told the truth.

(ii) Supposing that there is often (seen to be) a therapeutic justification for doctors deliberately deceiving their patients, it does not follow that lying to them is thereby justified. Even if, as in the above case, you are asked point blank, 'Have I got cancer?' you are not forced either to lie or tell. Suppose you agree with Dr Teller but think that it would be better for her to be told by her own doctor than by a relative stranger – you mean to persuade him to talk to her as soon as he returns. Meanwhile you can evade even a direct question without actually lying. You could say, perhaps: 'I don't know your case fully ... I have not talked about your case in depth with your specialist. You should talk to him.'

Many people fall in with a utilitarian approach to ethics – for them, our question as to when lying to patients is morally defensible turns on the overall harm/benefit of lying – whether it would be for the best to lie, bearing in mind all relevant interests (which would doubtless, include the interests of other people, for example, family, nursing staff). Once it is established as it surely would be, that in some cases deliberate deception *is* for the best, the further question of whether to accomplish it by a lie, or an equivocation, evasion or whatever becomes a mere technicality of no particular moral significance, to be decided again by applying the same procedure of weighing costs against benefits. Those who adopt this approach are understandably impatient with fine distinctions such as I have attempted – to them these are a practical irrelevance – certainly not to be inflicted on doctors addressing questions of medical ethics.

But this utilitarian approach to the ethics of lying seems to me to be radically misguided. The distinctions to which I drew attention in Part I were not proffered merely as an example of minute philosophising but as of *practical* relevance to the issues before us, for example, whether lying to patients is morally defensible.

As I argued in Part II the wrongness of lying is not to be located in the harm suffered by the person lied to – nor, I now would add, by the harm suffered generally, bearing in mind, for example, its effect on observers. It is to be explained rather in terms of the need a community (any community) has to maintain a firm rule against lying – a rule the function of which is to preclude lying as a practical option, as a possible method for achieving whatever aims we happen to have. And if as a community we need the rule we cannot allow ourselves the freedom to set aside the rule whenever an occasion presents where it appears that so doing would be for the best: that would be to abandon the rule – it would lose its essential function.

Yet the very question I have posed: 'When is lying to patients morally defensible?' rather invites us to adopt a utilitarian approach – it invites us to review the plight of patients in various situations to see whether lying is never, sometimes, or often, jusified. On my account of the wrongness of lying maybe we should not allow ourselves to be drawn into a discussion of what harm there is in setting this rule aside in regard to patient A or patient B.

Now some utilitarians would actually share my misgivings about what I have been calling the utilitarian approach and which they would call, rather, an act utilitarian approach. They too, as rule utilitarians, argue that there are certain rules which a community needs to uphold and which we should be learning to follow as a matter of course in our day-to-day activities without stopping to calculate consequences though meanwhile, they say, in our less active more reflective moments, we should be reviewing and revising our rules in the light of our day-to-day experience – seeking always to develop our rules so as to improve them (11).

How does the position I am advocating in regard to lying differ from that of the rule utilitarians? If the rule against lying is, as I have allowed, *prima facie*, it may on occasion be morally defensible for doctors to lie to their patients. How else then are we to decide on what occasion except by considering, as rule utilitarians do, what departures from the rule would be for the best?

But I have not defended a rule against lying on the grounds that we need to live by this rule so that we may achieve what is for the best. Why suppose it is *necessary* to aim for the best? We may doubt anyway whether that aim is even intelligible. Rather, I have maintained that we need the rule just so as to get by – whatever particular further aims we happen to have in life. If the rule would still allow us to get by if certain departures were generally allowed, then the departures *can* be allowed. If the rule would only allow us to get by if certain departures were allowed, then the departures *must* be allowed.

WHEN IS INTENTIONAL DECEPTION OF PATIENTS MORALLY DEFENSIBLE?

Suppose that many people think, as does Roger Higgs, that, morally speaking, deliberate deception and lying

are on the same footing. In their view then the one practice poses just as much of a threat to trust as does the other. Such a supposition, if it comes to be widely shared is self-fulfilling.

But I do not think that this view *is* widely shared. It is not shared, at any rate, outside the medical context: as I have argued, we practise deliberate deception on one another in a variety of ways that we believe pose no significant threat to trust: for example, by putting someone off the scent so as to keep a planned treat a surprise: a stratagem, it may be noted, which we play on our friends with whom we care most to preserve trust.

Perhaps, though, it can be shown that doctors have a special duty not to deceive their patients, a duty which derives from another duty universally acknowledged by doctors, *viz* their duty of care. While some might protest that it is this very duty of care which makes benevolent deception on occasion not just permissible but obligatory, it might be argued that on the contrary from the duty of care may be derived a duty to maintain trust (without which a patient cannot be got to follow advice) and, from that duty derives another, to refrain from deception. Thus Roger Higgs remarks: 'If truth is the first casualty, trust is the second' (12).

This pronouncement has a certain force and simplicity about it. On examination it is not so clear, though, what is being asserted. Firstly, should we go along with the assertion that the absence of truth is a casualty? A casualty for whom? After all, truth can be withheld without recourse to deception – and without any injury to those shielded from it: there are many things that we are better off not knowing (the result of a match if we are about to watch the replay) or that we ought not to be told (a doctor has many confidences to keep). Secondly, non-deceptive withholding of truth aside, it remains unclear whether the truth which is being said to underpin trust is a matter of not telling lies (my view) or also a matter of not deliberately deceiving (the Higgs view)? In other words, the saying could be cited in support of either view; it does not tell in favour of one against the other.

I conclude that while doctors generally speaking should have no truck with lying, deliberate deception need not in general pose a significant threat to trust.

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References

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(2) See reference (1): 194–195.
(3) See reference (1): 201.
(4) See reference (1): 189–190.
(5) See reference (1): 200.
(6) Hoffman F. *Medicus politicus*, part 3, ch 4, vol 5: 24: 'qui enim nescit simulare, nescit curare'. The *Medicus politicus* (separately paginated) is in the 'second part' of a two-volume *Operum omnium physico-medicorum supplementum*, Geneva, 1749. These two volumes are a supplement to Hoffman's *Opera omnia physico-medico* (6 vols). Geneva, 1748.
(7) See reference (1): 190–191.
(8) Securis J. *A detection and querimonie of the daily enormitites and abuses committed in physick*. London: 1566. SIG A iv recto. (This was the way pages were numbered at that time: by signature, by letter and number, and by right-hand [recto] or left-hand [verso] page.)
(9) See reference (8): SIG A iv verso.
(10) As reported by Sampson P. People who don't give stock responses the time of day. *The Sunday Times* 1990 Aug 19: 5–11 (cols 2–8).
(11) For recent discussion of rule utilitarian, or as some would now prefer, indirect utilitarian, ethics see the ongoing debate between R M Hare and his critics in: Seanor D, Fotion N, eds. *Hare and critics*. Oxford: Oxford University Press, 1988.
(12) See reference (1): 188.