Editorial

On telling dying patients the truth

Dr Lawrence Goldie, who specialises in psychotherapy for dying and severely ill patients, provides in this issue a persuasive case for honesty with such patients. The honesty he advocates involves painstaking and sensitive commitment, not five minutes of blunt speaking in a busy outpatient clinic (he gives a horrifying example of incompetent truth telling); it is an honesty which the patient has sought in the course of psychotherapeutically orientated discussion; it is an honesty which includes continuing support; and it is an honesty which, believes Dr Goldie, reduces unnecessary suffering and helps patients to survive it when it is inevitable. Such views, from a doctor who spends much of his professional life actually talking at length and in depth with patients who are dying deserve very serious consideration. Yet they probably represent a small minority of medical opinion on this issue. More commonly—in practice if not in print—doctors tend to deceive patients with fatal diseases (especially cancer) about both diagnosis and prognosis.

Three arguments defending such deception are often heard. The first is that the doctor’s primary moral obligation is not to harm his, or her, patient (primum non nocere) and that this obligation over-rides the requirement not to deceive: fatally ill patients already have enough problems of their own without the doctor harming them further by telling them that they have cancer and will probably soon die from it.

The second argument against truth telling is that the doctor can never be sure of the diagnosis or prognosis and in any case patients have not been trained to understand the truth even if they are told it: patients have insufficient comprehension of the intricacies of medicine; of the enormous variety of conditions encompassed by the word ‘cancer’; of the range of possible outcomes; of the pros and cons of various treatments, and thus, even if one wants to, it is usually impossible successfully to communicate the truth. An American physician combined these two arguments long ago when he wrote: ‘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 . . . far older than the precept ‘the whole truth and nothing but the truth’ is another that originates within our profession, that has always been the guide of the best physicians and if I may venture a prophecy will always remain so:“so far as possible do no harm. . . .”(1).

The third argument against truth telling is that patients do not wish to be told the truth when they have a fatal illness and not much longer to live. It is perhaps worth briefly considering each of these arguments.

Primum non nocere is certainly a vital principle of medical ethics but its priority or absoluteness and its exact meaning may both be questioned. Clearly the principle can not entail that anything which causes harm to a patient must be avoided: operations for example cause some harm and certain life-prolonging and potentially curative cancer treatments may cause severely harmful side-effects. The principle must be understood to mean that the doctor should strive to ensure that his interventions achieve a positive balance of benefit over harm. Yet even this principle cannot be given absolute priority otherwise the doctor’s safest course would always be to leave well alone, thereby ensuring that he was not ever causing more harm than good (this assertion admittedly ignores the philosophical problem of whether or not one can cause things to happen by inaction). If, as seems essential, primum non nocere is understood in this modified way then it can not justify deceiving patients unless (a) the failure to deceive would result in an overall excess of harm over benefit and (b) the net avoidance of harm achieved by deceit outweighed any other relevant moral principles.

It is indisputable that most people suffer anguish when they learn that they have a fatal disease which is likely to kill them. Far less obvious is that such information causes more harm than good, for against the anguish must be set such benefits as: relief of uncertainty (many such people already suspect that something is seriously wrong); the possibility of informed reflection and discussion about the likely course of events; the opportunity to take stock, mend bridges, make farewells, arrange affairs and even help family and friends to come to terms with their loved one’s impending death; the avoidance of the extensive web of deceit in which an initially limited medical (or family) decision to deceive often results — deceit which may supplant a lifetime’s mutual trust; and finally the amelioration of the process of dying which honest preparation for death may achieve. Apart from Dr Goldie’s own examples of the benefits of honesty in terminal disease a vivid example is provided in a recent JME Case conference (2) (see also this issue’s Case conference). Thus even on mere harm-benefit
calculations there is good reason to doubt that deceit will
generally be of overall benefit to the dying patient. For
non-utilitarians such calculations are in any case not
sufficient; the maximising of overall good is only one of
many moral principles which may be relevant. Others
include those various principles which may con-
veniently be subsumed under the concept of respect for
the individual person. The moral principles that one
should tell the truth, honour one's promises and con-
tracts, and keep faith with others, are all examples of
respect for persons. Another is the principle of auton-
omy which recognises the individual's right to deter-
dine his own preferences, make his own moral
decisions and generally determine his own course of
action at least in so far as it does not conflict with the
autonomy of others. Such principles might lead the
non-utilitarian to avoid deceptions and respect a
patient's autonomy even in cases where he did foresee
that this would result in overall harm to the patient.

The second argument is that doctors are unable
to tell patients the truth because patients are unable to
understand it and in any case doctors can never them-

selves know it to be the truth, for their diagnoses and
especially their prognoses are often wrong (most doc-
tors have dramatic stories to illustrate this). This
argument involves a fundamental confusion between
the moral issues of truth telling or truthfulness and
deceit on the one hand and the logical, semantic and
epistemological issues besetting the concept of truth
itself on the other. While these latter issues are of
central importance in philosophy they have almost
nothing to do with the question of what to do with such
knowledge of the truth as one does have. Here the
crucial moral issue concerns the doctor's intention;
does he intend to transmit to the patient information he
has reason to believe to be true, does he intend to
withhold it, or does he intend to lie to or otherwise
deceive the patient? Discussions about the concept of
truth, about how we can know the truth, especially
where information is probabilistic, and about different
degrees of understanding of what is known or justifi-
ably believed to be true, are all but a smokescreen
which does nothing (in the ordinary case) to resolve the
dilemmas of truthfulness and deceit. Those with
residual doubts should imagine, as Sissela Bok in her
excellent discussion of lying suggests, what their
response would be to a used-car dealer who used such
arguments to justify his deceit (3).

Finally, there is the argument that patients do not
wish to be told the truth about their fatal condition.
This is an important argument for it implicitly recog-
nises that doctors ought to be responsive to their
patients' wishes - it recognises implicitly the autonomy
of patients. If it could be shown that all patients did
indeed wish not to be told the truth about their fatal
diseases this would be an important argument at least
for withholding the truth. However several surveys (4,
5, 6, 7) have shown that a large majority, generally
over 80 per cent, of patients and the general public say
that they would like to be told the truth. On the other
hand almost 90 per cent of American doctors generally
withheld the truth about cancer diagnoses from their
patients (8). Although these surveys are now distinctly
elderly they at least cast substantial doubt upon the
claim that most patients do not wish to know the truth.

One possible explanation for the discrepancy be-
tween what doctors believe about patients' wishes and
what patients say they wish is the one suggested by Dr
Goldie, and supported by another study (9), that doc-
tors find death, and especially the prospect of their own
death, particularly disturbing. Certainly, talking hon-
estly with patients about their death is disturbing, a
profoundly moving experience, and perhaps one of the
more difficult tasks with which a doctor may be faced.
Nonetheless if it was recognised more generally to be
an important and legitimate aspect of his role then ways
of ameliorating his disturbance, including appropriate
training, good support and a reasonable distribution of
this type of work-load, could doubtless be devised with
the assistance of those experienced in such work.

The foregoing arguments do not, it should be
emphasised, support indiscriminate, let alone casual,
curt or unsupporting, truth telling to all dying
patients. Rather they are arguments which reject any
blanket generalisation in this complex area. They do
however indicate that a concern for the autonomy of
the patient requires a sincere effort to be made to
discover what his, or her, wishes really are, and then to
give those wishes very considerable weight. They sug-
uggest that the basic moral norms of truth telling and
fidelity cannot lightly be over-ridden; and they suggest
that when assessing overall harm and benefit, more
complex assessment is required than a mere considera-
tion of the patient's immediate distress on being told
the truth. Finally they suggest that strategies need to
be developed to help medical staff deal with their own
distress when confronted by such problems.

References

(1) Henderson L. Physician and patient as a social system.

(2) Higgs R. ed. Truth at the last - a case of obstructed

(3) Bok S. Lying - moral choice in public and private life.

(4) Veatch R. Death, dying and the biological revolution. New
Haven and London: Yale University Press, 1976;
229-238.

(5) Aitken-Swan J, Easson E C. Reactions of cancer patients
on being told their diagnoses. British medical journal
1959; (i); 779-783.

(6) McIntosh J. Patients' awareness and desire for informa-
tion about diagnosed but undisclosed malignant disease.
Lancet 1976; 7; 300-303.

(7) Kelly W D, Friesen S R. Do cancer patients want to be

(8) Oken D. What to tell cancer patients. Journal of the

(9) Feiffel H, Hanson S, Jones, R et al. Physicians consider
death. Proceedings of the American Psychological Associa-