
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 conveniently 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 contracts, and keep faith with others, are all examples of respect for persons. Another is the principle of autonomy which recognises the individual's right to determine 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 themselves know it to be the truth, for their diagnoses and especially their prognoses are often wrong (most doctors 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 justifiably 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 recognises 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 between 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 doctors find death, and especially the prospect of their own death, particularly disturbing. Certainly, talking honestly 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 suggest 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 consideration 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

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