

Telling Patients the Truth

Denis Soler

“And you shall know the truth, and the truth shall make you free” (John 8:32)

One of the dilemmas that any practitioner attending a seriously sick/ terminally ill patient experiences is whether he should tell the patient all the truth about the seriousness of his illness or not.¹

For physicians throughout the ages, one of the weightiest questions has centred on their responsibility to inform a dying patient about the seriousness of his condition.

There is no one universal formula, which can be applied in all instances. Contrary to much of the doctor's work, there is not a routine he can fall back on. Rather, his experience will guide him in determining what a particular patient's needs are.

The doctor, as an expert, is expected to provide thorough information by explaining to the patient the diagnosis, the prognosis and the treatment options and this goes beyond giving out simple information. In this manner, the doctor is creating the basis of autonomy for the patient, the ability to make informed choices as finally the patient has a sacrosanct right to actively participate in the management of his health. I personally always have serious doubts as to what “free” really means and whether the patient would rather be free in that sense.

In this regard there are 2 major philosophical schools of thought.²

1. **Utilitarian** – for whom the overriding moral principle is to maximise welfare and minimise harm. However the principle of respect for autonomy is still a crucial moral one.
2. **Kantian** – who believe that respect for people and their autonomy is itself the overriding moral principle.

Against telling patients the truth

One of the main reasons given by those who advocate this attitude is that the truth would prove a source of great distress to a patient with serious or fatal disease. It is also generally thought that a seriously ill patient is not psychologically equipped to receive news of a certain nature.

Truth telling goes beyond providing more information. Truth is not just the opposite of a lie, not just the sum of correct

statements; it is a reciprocal state in the doctor – patient relationship which is established on the basis of mutual responsibilities.

In this context, failing to respect patients' autonomy by denying them adequate information for rational deliberation amounts to deception.

The case for “deception” of patients is usually based on 3 main arguments elegantly dissected among other, by Sisela Bok³ in her book *Lying*.

1. The first argument in favour of deception is that doctors' Hippocratic obligations to benefit (principle of beneficence) and not harm (principle of non-maleficence) their patients, override any requirement of not deceiving people. People with serious illness are already distressed and the doctor may aggravate their condition by giving them distressing news; their prospects of recovery, which very often depend on their morale and some placebo effect by doctor's attention has on the patient, may be hindered.
2. The second argument in favour of not telling the truth is that it cannot really be communicated, both because a doctor is rarely sure of the prognosis and also because the patient is rarely educated and informed well enough to fully comprehend the wide range of technical nuances divulged by the doctor.
Another view is that patients can never acquire enough knowledge to fully and appropriately participate in their care. As a result, the doctor remains a powerful, distant figure exercising unilateral decisions on the basis of knowledge that is assumed incommunicable. There is a tendency on the part of the doctor to adopt a paternalistic attitude and dictate what, to his mind, is best for the patient.
3. The third 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. This is an important argument as it implicitly presupposes that doctors ought to respect their patients' wishes.

For telling patients the truth

- I. **Deception** is morally unacceptable unless there is strong reason to believe that, in a particular case, overall welfare would be maximised by deception.⁴ Furthermore, honesty and frankness on the part of the doctor generates a stronger doctor – patient bond and this in turn can only increase the patient's welfare. Medical paternalism should not take over as patients are probably in a position

Denis Soler MD, FRCGP (UK)
Department of Family Medicine, Faculty of Medicine and Surgery
University of Malta, Msida, Malta
Email: densoler@maltanet.net

to judge whether knowing the truth about unpleasant facts would or would not improve their welfare. Doctors can master this difficult art by offering to answer questions and giving adequate time for this. There is probably no other instance in one's life which requires so much of a doctor's time; and a good doctor will know how much time and attention a particular patient requires. Denial by patients of serious problems is a natural defence mechanism which could indicate to doctors what, when and how much to divulge to a particular patient.

II. **Impossibility of communicating the truth.** Truth is beset with semantic, logical and communication problems and these 3 issues are of central importance in philosophy. What exactly constitutes the truth? Can anyone expressing a personal opinion, often based on empirical data, tell the whole truth? Communication skills vary from person to person, so is it always possible to communicate the truth? Truth implies that the information passed on to the patient reflects exactly a particular state of affairs, but how sure can a doctor be that he is presenting a true picture of the patient's condition?

III. In actual fact, the problems mentioned above have little to do with the question of what is right to do with such knowledge as finally the crucial moral question is "**What are the doctor's intentions**"? In particular does he intend to discover what the patient would wish to know and does he intend to try and meet such wishes when they concern the transmission of information the doctor believes to be both true and distressing to the patient or does he intend to deceive the patient?

IV. **Patients' wish not to know.** Various studies indicate a varying proportion of patients who want to know the truth and an equally varying number of doctors who are prepared to tell patients all the truth. So rather than generalise, one must consider what a particular patient's wishes in the circumstances of the case. Quite commonly too, relatives try to persuade the doctor not to tell the patient the truth and a ritual usually ensues composed of sotto voce conversations between the doctor and the patient's relatives, usually outside the patient's room. Doctors should heed what relatives have to say but must, in the end make some judicious decisions regarding what to tell the patient as finally the relatives' wishes may not reflect those of the patient.

V. **Patient's may have vitally important duties** which they could carry out only if they were given such information. This could take the form of settling outstanding accounts, making a last will or finding final spiritual solace. Real harm rarely results from honesty in response to patients who want reliable information about their condition.

In **America** it is an ethical duty of doctors to provide patients with essential information.⁵ Truth telling and respect for autonomy have become virtual moral absolutes in that country. Admittedly, other considerations, primarily litigation, play an important role.

In **Italy** the code of the Italian Medical Association used to include the following statement: "A serious or lethal prognosis can be hidden from the patient but not from the family."

It was revised in 1989 to read as follows: "The physician has the duty to provide the patient, according to his cultural level and abilities to understand, the most serene information about the diagnosis, the prognosis and the therapeutic perspectives and their consequences; in the awareness of the limits of medical knowledge, in the respect of the person's rights, to foster the best compliance to the therapeutic proposals. Each question asked by the patient has to be accepted and answered clearly. The physician might evaluate, specifically in relationship with the patient's reactions, the opportunity not to reveal to the patient, or to mitigate a serious or lethal prognosis. In this case, it will have to be communicated to the family. In any event, the patient's will, freely expressed, should represent for the physician an element which he will inspire his behaviour."

In Spain, a study among health workers showed that 71% would want to know the diagnosis should they suffer from cancer in future.⁶ Apparently there is a phenomenon, which owes its roots to cultural traditions, a so called cancer taboo, which is not conducive to mandatory uniform disclosure of the true diagnosis at present.

A study from Greece showed that the answer to the straightforward question "Do the Greeks wish to be informed of the nature of their illness?" was a "no", qualified by a cautious "it depends".⁷ Factors determining willingness or otherwise for receiving such information include age, education, family status, occupation and whether a person was deeply religious or not. Males and females were equally divided in their opinion. The author highlights the importance of good communication between doctors and patients and concludes that doctors should not lie, but should disclose to their patients the part of the truth they are ready to accept.

What is the situation in Malta?

It appears there are no official guidelines on the subject of truth telling. There is however no doubt that doctors in Malta would welcome, and probably benefit from, some form of guideline on the subject by a competent body. In view of the fact that to date, neither the Medical Council nor the Medical Association of Malta, have tackled the problem, I take this opportunity to urge the Malta College of Family Doctors to put this subject on its agenda and seek to provide, possibly together with the Institute of Health Care and the Hospice Movement, clear guidelines for Maltese Health workers.

Is Medical Ethics a cultural artefact such that a universal medical ethic is not possible?⁸

I believe that ethics is inevitably connected to cultural values and therefore varies in different societies. What may be

considered beneficent in one country may seem maleficent in another. This contrast in moral perspectives requires an implicit understanding of the dichotomy between believing in values and respecting the pluralism of different cultures.

The situation everywhere is evolving rapidly, with malpractice suits in other countries increasing and public scepticism of physicians on the rise.

For now, when I deal with seriously ill patients, I try to tell them the complete truth. However, there are times when this is not easy. In all instances, I make an effort to listen to them and respect their need for information. Since I believe that the suffering person knows the truth, I think the only way to respect all ethical principles is to let the patient know that there are no barriers to communication and the truth.

I do not believe that Maltese society should borrow the American, English or Italian way but it should learn from all these to perhaps find a better Maltese way. I will endeavour, along with other interested parties to contribute towards a positive change in our society.

"In much wisdom is much grief; and he that increaseth knowledge, increaseth sorrow" (Ecclesiastes 1,18)

How true this must be when the patient is a doctor.

References

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The Dr Thomas Chetcuti - BOV Prize in Psychiatry



The Department of Psychiatry has held this prize for the third year in succession and many thanks are due to Bank of Valletta for its sponsorship. The purpose of the prize is to celebrate studenthood and effort. Where in previous years it was awarded to the first two persons in the course, this year's awardees were four in number; Dr Neville Azzopardi, Dr Gerald Busuttil, Dr Daniela Farrugia and Dr Nadia Sciberras Innes, all achieving joint first place in last year's course. Our congratulations go to them. The prize consists of books on Melitensia.

Dr Thomas Chetcuti may very well be called the pioneer Maltese psychiatrist. Responsible for psychiatric services between 1838 and 1863, he was the first Maltese physician to make a serious study of mental disorder and to devote the greater part of his life and energy to the care and treatment of the mentally sick.

Giving importance to both physical and psychological treatments and introducing occupational therapy, he liberated patients from their chains, introduced major changes in hospital quality of life, governed by force of example and impressed on attendants the need for gentleness. (Cassar Paul 1965, Medical History of Malta, 366-368 and Savona Ventura Charles 1997, Outlines of Maltese Medical History, 56)

Medical students consistently give very strong and positive feedback to our course and this derives from the dedication, hard work and effort of team members including Dr Joseph Cassar, Dr Ethel Felice, Dr Anton Grech, Dr Etienne Muscat, and Dr Peter Muscat; from Sedqa Dr Moses Camilleri, Dr George Grech and Dr Anna Vella and multiple Agencies, NGOs, nurses, psychologists, social workers, occupational therapists and administrative staff and not least, patients and their families. Much appreciation and thanks is due to all.