That honesty should be an important issue for debate in medical circles may seem bizarre. Nurses and doctors are usually thought of as model citizens. Outside the immediate field of health care, when a passport is to be signed, a reference given, or a special allowance made by a government welfare agency, a nurse’s or doctor’s signature is considered a good warrant, and false certification treated as a serious breach of professional conduct. Yet at the focus of medical activity or skill, at the bedside or in the clinic, when patient meets professional there is often doubt. Is the truth being told?

Many who are unfamiliar with illness and its treatment may well be forgiven for wondering if this doubt has not been exaggerated. It is as if laundry-men were to discuss the merits of clean clothes, or fishmongers of refrigeration. But those with experience, either as patients or professionals, will immediately recognize the situation. Although openness is increasingly practised, there is still uncertainty in the minds of many doctors or nurses faced with communicating bad news; as for instance when a test shows up an unexpected and probably incurable cancer, or when meeting the gaze of a severely ill child, or answering the questions of a mother in mid-pregnancy whose unborn child is discovered to be badly handicapped. What should be said? There can be few who have not, on occasions such as these, told less than the truth. Certainly the issue is a regular preoccupation of nurses and doctors in training. Why destroy hope? Why create anxiety, or something worse? Isn’t it ‘First, do no harm’?

The concerns of the patient are very different. For many, fear of the unknown is the worst disease of all, and yet direct information seems so hard to obtain. The ward round goes past quickly, unintelligible words are muttered – was I supposed to hear and understand? In the surgery the general practitioner signs his prescription pad and clearly it’s time to be gone. Everybody is too busy saving lives to give explanations. It may come as a shock to learn that it is policy, not just pressure of work, that prevents a patient learning the truth about himself. If truth is the first casualty, trust must be the second. ‘Of course they wouldn’t say, especially if things were bad,’ said the elderly woman just back from out-patients, ‘they’ve got that Oath, haven’t they?’ She had learned to expect from doctors, at the best, silence; at the worst, deception. It was part of the system, an essential ingredient, as old as Hippocrates. However honest a citizen, it was somehow part of the doctor’s job not to tell the truth to his patient…

It is easier to decide what to do when the ultimate outcome is clear. It may be much more difficult to know what to say when the future is less certain, such as in the first episode of what is probably multiple
sclerosis, or when a patient is about to undergo a mutilating operation. But even in work outside hospital, where such dramatic problems arise less commonly, whether to tell the truth and how much to tell can still be a regular issue. How much should this patient know about the side effects of his drugs? An elderly man sits weeping in an old people’s home, and the healthy but exhausted daughter wants the doctor to tell her father that she’s medically unfit to have him back. The single mother wants a certificate to say that she is unwell so that she can stay at home to look after her sick child. A colleague is often drunk on duty, and is making mistakes. A husband with venereal disease wants his wife to be treated without her knowledge. An outraged father demands to know if his teenage daughter has been put on the pill. A mother comes in with a child to have a boil lanced. ‘Please tell him it won’t hurt.’ A former student writes from abroad needing to complete his professional experience and asks for a reference for a job he didn’t do. Whether the issue is large or small, the truth is at stake. What should the response be?

Discussion of the apparently more dramatic situations may provide a good starting-point. Recently a small group of medical students, new to clinical experience, were hotly debating what a patient with cancer should be told. One student maintained strongly that the less said to the patient the better. Others disagreed. When asked whether there was any group of patients they could agree should never be told the truth about a life-threatening illness, the students chose children, and agreed that they would not speak openly to children under six. When asked to try to remember what life was like when they were six, one student replied that he remembered how his mother had died when he was that age. Suddenly the student who had advocated non-disclosure became animated. ‘That’s extraordinary. My mother died when I was six too. My father said she’d gone away for a time, but would come back soon. One day he said she was coming home again. My younger sister and I were very excited. We waited at the window upstairs until we saw his car drive up. He got out and helped a woman out of the car. Then we saw. It wasn’t mum. I suppose I never forgave him — or her, really.’

It is hard to know with whom to sympathize in this sad tale. But its stark simplicity serves to highlight some essential points. First, somehow more clearly than in the examples involving patients, not telling the truth is seen for what it really is. It is, of course, quite possible, and very common in clinical practice, for doctors (or nurses) to engage in deliberate deceit without actually saying anything they believe to be false. But, given the special responsibilities of the doctor, and the relationship of trust that exists between him and his patient, one could hardly argue that this was morally any different from telling outright lies. 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. The debate in ward or surgery is suddenly stood on its head. The question is no longer ‘Should we tell the truth?’ but ‘What justification is there for telling a lie?’ This relates to the second important point, that medical ethics are part of general morality, and not a separate field of their own with their own rules. Unless there are special justifications, health-care professionals are working within the same moral constraints as lay people. A lie is a lie wherever told and whoever tells it.

But do doctors have a special dispensation from the usual principles that guide the conduct of our society? It is widely felt that on occasion they do, and such a dispensation is as necessary to all doctors as freedom from the charge of assault is to a surgeon. But, if it is impossible to look after ill patients and always be open and truthful, how can we balance this against the clear need for truthfulness on all other occasions? If deception is like a medicine to be given in certain doses in certain cases, what guidance exists about its administration?

My elderly patient reflected the widely held view that truth-telling, or perhaps withholding, was part of the tradition of medicine enshrined in its oaths and codes. Although the writer of the ‘Decorum’ in the Hippocratic corpus advises physicians of the danger of telling patients about the nature of their illness ‘… for many patients through this cause have taken a turn for the worse’, the Oath itself is completely silent on this issue. This extraordinary omission is continued through all the more modern codes and declarations. The first mention of veracity as a principle is to be found in the American Medical Association’s ‘Principles of Ethics’ of 1980, which states that the
physician should ‘deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud and deception’.\textsuperscript{5} Despite the difficulties of the latter injunction, which seems in some way to divert attention from the basic need for honest communication with the patient, here at last is a clear statement. This declaration signally fails, however, to provide the guidance that we might perhaps have expected for the professional facing his or her individual dilemma.

The reticence of these earlier codes is shared, with some important exceptions, by medical writing elsewhere. Until recently most of what had been usefully said could be summed up by the articles of medical writers such as Thomas Percival, Worthington Hooker, Richard Cabot, and Joseph Collins, which show a wide scatter of view points but do at least confront the problems directly.\textsuperscript{6} There is, however, one widely quoted statement by Lawrence Henderson, writing in the New England Journal of Medicine in 1955.\textsuperscript{7} ‘It is meaningless to speak of telling the truth, the whole truth and nothing but the truth to a patient… because it is… a sheer impossibility… Since telling the truth is impossible, there can be no sharp distinction between what is true and what is false.’

But we must not allow ourselves to be confused, as Henderson was, and as so many others have been, by a failure to distinguish between truth, the abstract concept, of which we shall always have an imperfect grasp, and telling the truth, where the intention is all important. Whether or not we can ever fully grasp or express the whole picture, whether we know ultimately what the truth really is, we must speak truthfully, and intend to convey what we understand, or we shall lie. In Sissela Bok’s words, ‘The moral question of whether you are lying or not is not settled by establishing the truth or falsity of what you say. In order to settle the question, we must know whether you intend your statement to mislead.’\textsuperscript{8}

Most modern thinkers in the field of medical ethics would hold that truthfulness is indeed a central principle of conduct, but that it is capable of coming into conflict with other principles, to which it must occasionally give way. On the other hand, the principle of veracity often receives support from other principles. For instance, it is hard to see how a patient can have autonomy, can make a free choice about matters concerning himself, without some measure of understanding of the facts as they influence the case; and that implies, under normal circumstances, some open, honest discussion with his advisers.\textsuperscript{9} Equally, consent is a nonsense if it is not in some sense informed…

Once the central position of honesty has been established, we still need to examine whether doctors and nurses really do have, as has been suggested, special exemption from being truthful because of the nature of their work, and if so under what circumstances… 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 apologizes by saying, ‘I hope you don’t mind me calling you at this time, doctor’, and the doctor replies, ‘No, not at all.’). However… occasions of these two types are few, fewer than those in which deliberate deceit would generally be regarded as acceptable in current medical practice, and should regularly be debated ‘in public’ if abuses are to be avoided.\textsuperscript{10} To this end it is necessary now to examine critically the arguments commonly used to defend lying to patients.

First comes the argument that it is enormously difficult to put across a technical subject to those with little technical knowledge and understanding, in a situation where so little is predictable. A patient has bowel cancer. With surgery it might be cured, or it might recur. Can the patient understand the effects of treatment? The symptom she is now getting might be due to cancer, there might be secondaries, and they in turn might be suppressible for a long time, or not at all. What future symptoms might occur, how long will she live, how will she die — all these are desperately important questions for the patient, but even for her doctor the answers can only be informed guesses, in an area where uncertainty is so hard to bear.

Yet to say we do not know anything is a lie. As doctors we know a great deal, and can make informed guesses or offer likelihoods. The whole truth may be impossible to attain, but truthfulness is not. ‘I do not know’ can be a major piece of honesty. To deprive the patient of honest communication because we cannot know everything is, as we have seen, not only confused thinking but immoral. Thus deprived, the
patient cannot plan, he cannot choose. If choice is the crux of morality, it may also, as we have argued elsewhere, be central to health. If he cannot choose, the patient cannot ever be considered to be fully restored to health.\footnote{11}

This argument also raises another human failing – to confuse the difficult with the unimportant. Passing information to people who have more restricted background, whether through lack of experience or of understanding, can be extremely difficult and time-consuming, but this is no reason why it should be shunned. Quite the reverse. Like the difficult passages in a piece of music, these tasks should be practised, studied, and techniques developed so that communication is efficient and effective. For the purposes of informed consent, the patient must be given the information he needs, as a reasonable person, to make a reasoned choice.

The second argument for telling lies to patients is that no patient likes hearing depressing or frightening news. That is certainly true. There must be few who do. But in other walks of life no professional would normally consider it his or her duty to suppress information simply in order to preserve happiness. No accountant, foreseeing bankruptcy in his client’s affairs, would chat cheerfully about the Budget or a temporarily reassuring credit account. Yet such suppression of information occurs daily in wards or surgeries throughout the country. Is this what patients themselves want?

In order to find out, a number of studies have been conducted over the past thirty years.\footnote{12} In most studies there is a significant minority of patients, perhaps about a fifth, who, if given information, deny having been told. Sometimes this must be pure forgetfulness, sometimes it relates to the lack of skill of the informer, but sometimes with bad or unwelcome news there is an element of what is (perhaps not quite correctly) called ‘denial’. The observer feels that at one level the news has been taken in, but at another its validity or reality has not been accepted. This process has been recognized as a buffer for the mind against the shock of unacceptable news, and often seems to be part of a process leading to its ultimate acceptance.\footnote{13} But once this group has been allowed for, most surveys find that, of those who have had or who could have had a diagnosis made of, say, cancer, between two-thirds and three-quarters of those questioned were either glad to have been told, or declared that they would wish to know. Indeed, surveys reveal that most doctors would themselves wish to be told the truth, even though (according to earlier studies at least) most of those same doctors said they would not speak openly to their patients – a curious double standard! Thus these surveys have unearthed, at least for the present, a common misunderstanding between doctors and patients, a general preference for openness among patients, and a significant but small group whose wish not to be informed must surely be respected. We return once more to the skill needed to detect such differences in the individual case, and the need for training in such skills.

Why doctors have for so long misunderstood their patients’ wishes is perhaps related to the task itself. Doctors don’t want to give bad news, just as patients don’t want it in abstract, but doctors have the choice of withholding the information, and in so doing protecting themselves from the pain of telling and from the blame of being the bearer of bad news. In addition it has been suggested that doctors are particularly fearful of death and illness. Montaigne suggested that men have to think about death and be prepared to accept it, and one would think that doctors would get used to death. Yet perhaps this very familiarity has created an obsession that amounts to fear. Just as the police seem over-concerned with violence, and firemen with fire, perhaps doctors have met death in their professional training only as the enemy, never as something to come to terms with, or even as a natural force to be respected and, when the time is ripe, accepted or even welcomed.

Undeniably, doctors and nurses like helping people and derive much satisfaction from the feeling that the patient is being benefited. This basic feeling has been elevated to major status in medical practice. The principle of beneficence – to work for the patient’s good – and the related principle of non-maleficence – ‘first do no harm’ – are usually quoted as the central guiding virtues in medicine. They are expanded in the codes, and underlie the appeal of utilitarian arguments in the context of health care. ‘When you are thinking of telling a lie,’ Richard Cabot quotes a teacher of his as saying, ‘ask yourself whether it is simply and solely for the patient’s benefit that you are going to tell it. If
you are sure that you are acting for his good and not for your own profit, you can go ahead with a clear conscience.'14 But who should decide what is ‘for the patient’s benefit’? Why should it be the doctor? Increasingly society is uneasy with such a paternalistic style. In most other walks of life the competent individual is himself assumed to be the best judge of his own interests. Whatever may be thought of this assumption in the field of politics or law, to make one’s own decisions on matters that are central to one’s own life or welfare and do not directly concern others would normally be held to be a basic right; and hardly one to be taken away simply on the grounds of one’s own life or welfare and do not directly concern others would normally be held to be a basic right; and hardly one to be taken away simply on the grounds of illness, whether actual or merely potential.

Thus if beneficence is assumed to be the key principle, which many now have come to doubt, it can easily ride roughshod over autonomy and natural justice. A lie denies a person the chance of participating in choices concerning his own health, including that of whether to be a ‘patient’ at all. Paternalism may be justifiable in the short term, and to ‘kid’ someone, to treat him as a child because he is ill, and perhaps dying, may be very tempting. Yet true respect for that person (adult or child) can only be shown by allowing him allowable choices, by granting him whatever control is left, as weakness gradually undermines his hold on life. If respect is important then at the very least there must be no acceptable or effective alternative to lying in a particular situation if the lie is to be justified…

However, a third argument for lying can be advanced, namely, that truthfulness can actually do harm. ‘What you don’t know can’t hurt you’ is a phrase in common parlance (though it hardly fits with concepts of presymptomatic screening for preventable disease!). However, it is undeniable that blunt and unfeeling communication of unpleasant truths can cause acute distress, and sometimes long-term disability. The fear that professionals often have of upsetting people, of causing a scene, of making fools of themselves by letting unpleasant emotions flourish, seems to have elevated this argument beyond its natural limits. It is not unusual to find that the fear of creating harm will deter a surgical team from discussing a diagnosis gently with a patient, but not deter it from performing radical and mutilating surgery. Harm is a very personal concept. Most medical schools have, circulating in the refectory, a story about a patient who was informed that he had cancer and then leapt to his death. The intended moral for the medical student is, keep your mouth shut and do no harm. But that may not be the correct lesson to be learned from such cases (which I believe, in any case, to be less numerous than is commonly supposed). The style of telling could have been brutal, with no follow-up or support. It may have been the suggested treatment, not the basic illness, that led the patient to resort to such a desperate measure. Suicide in illness is remarkably rare, but, though tragic, could be seen as a logical response to an overwhelming challenge. No mention is usually made of suicide rates in other circumstances, or the isolation felt by ill and warded patients, or the feelings of anger uncovered when someone takes such precipitate and forbidden action against himself. What these cases do, surely, is argue, not for no telling, but for better telling, for sensitivity and care in determining how much the patient wants to know, explaining carefully in ways the patient can understand, and providing full support and ‘after-care’ as in other treatments.

But even if it is accepted that the short-term effect of telling the truth may sometimes be considerable psychological disturbance, in the long term the balance seems definitely to swing the other way. The effects of lying are dramatically illustrated in ‘A Case of Obstructed Death?’15 False information prevented a woman from returning to healthy living after a cancer operation, and robbed her of six months of active life. Also, the long-term effect of lies on the family and, perhaps most importantly, on society, is incalculable. If trust is gradually corroded, if the ‘wells are poisoned’, progress is hard. Mistrust creates lack of communication and increased fear, and this generation has seen just such a fearful myth created around cancer.16 Just how much harm has been done by this ‘demolishing’ of cancer, preventing people coming to their doctors, or alternatively creating unnecessary attendances on doctors, will probably never be known.

There are doubtless many other reasons why doctors lie to their patients; but these can hardly be used to justify lies, even if we should acknowledge them in passing. Knowledge is power, and certainly doctors, though usually probably for reasons of work-load rather than anything more sinister, like to remain ‘in control’. Health professionals may, like others, wish to
protect themselves from confrontation, and may find it easier to coerce or manipulate than to gain permission. There may be a desire to avoid any pressure for change. And there is the constant problem of lack of time. But, in any assessment, the key issues remain. Not telling the truth normally involves telling lies, and doctors and nurses have no carte blanche to lie…

If the importance of open communication with the patient is accepted, we need to know when to say what. If a patient is going for investigations, it may be possible at that time, before details are known, to have a discussion about whether he would like to know the details. A minor ‘contract’ can be made. ‘I promise to tell you what I know, if you ask me.’ Once that time is past, however, it requires skill and sensitivity to assess what a patient wants to know. Allowing the time and opportunity for the patient to ask questions is the most important thing, but one must realize that the patient’s apparent question may conceal the one he really wants answered. ‘Do I have cancer?’ may contain the more important questions ‘How or when will I die?’ ‘Will there be pain?’ The doctor will not necessarily be helping by giving an extended pathology lesson. The informer may need to know more: ‘I don’t want to avoid your question, and I promise to answer as truthfully as I can, but first…’ It has been pointed out that in many cases the terminal patient will tell the doctor, not vice versa, if the right opportunities are created and the style and timing is appropriate. Then it is a question of not telling but listening to the truth.17

If in spite of all this there still seems to be a need to tell lies, we must be able to justify them. That the person is a child, or ‘not very bright’, will not do. Given the two ends of the spectrum of crisis and triviality, the vast middle range of communication requires honesty, so that autonomy and choice can be maintained. If lies are to be told, there really must be no acceptable alternative. The analogy with force may again be helpful here; perhaps using the same style of thinking as is used in the Mental Health Act, to test whether we are justified in removing someone’s liberty against their will, may help us to see the gravity of what we are doing when we consider deception. It also suggests that the decision should be shared, in confidence, and be subject to debate, so that any alternative which may not initially have been seen may be considered. And it does not end there. If we break an important moral principle, that principle still retains its force, and its ‘shadow’ has to be acknowledged. As professionals we shall have to ensure that we follow up, that we work through the broken trust or the disillusionment that the lie will bring to the patient, just as we would follow up and work through bad news, a major operation, or a psychiatric ‘sectioning’. This follow-up may also be called for in our relationship with our colleagues if there has been major disagreement about what should be done.

In summary, there are some circumstances in which the health professions are probably exempted from society’s general requirement for truthfulness. But not telling the truth is usually the same as telling a lie, and a lie requires strong justification. Lying must be a last resort, and we should act as if we were to be called upon to defend the decision in public debate, even if our duty of confidentiality does not allow this in practice. We should always aim to respect the other important principles governing interactions with patients, especially the preservation of the patient’s autonomy. When all is said and done, many arguments for individual cases of lying do not hold water. Whether or not knowing the truth is essential to the patient’s health, telling the truth is essential to the health of the doctor–patient relationship.

Notes

1 Primum non nocere – this is a Latinization of a statement which is not directly Hippocratic, but may be derived from the Epidemics Book 1 Chapter II: ‘As to diseases, make a habit of two things – to help, or at least do no harm.’ Hippocrates, 4 vols (London: William Heinemann, 1923–31), vol. I, trans. W. H. S. Jones.
2 Cases collected by the author in his own practice.
3 Case collected by the author.
4 Quoted in Reiser, Dyck, and Curran (eds), Ethics in Medicine, Historical Perspectives and Contemporary Concerns (Cambridge, MA: MIT Press, 1977).
6 To be found in Reiser et al., *Ethics in Medicine*.
11 See Campbell and Higgs, *In That Case*.
13 The five stages of reacting to bad news, or news of dying, are described in *On Death and Dying* by Elizabeth Kubler-Ross (London: Tavistock, 1970). Not everyone agrees with her model. For another view see a very stimulating article ‘Therapeutic Uses of Truth’ by Michael Simpson in E. Wilkes (ed.), *The Dying Patient* (Lancaster: MTP Press, 1982). ‘In my model there are only two stages – the stage when you believe in the Kubler-Ross five and the stage when you do not.’
17 Cicely Saunders, ‘Telling Patients’, *District Nursing* (now *Queens Nursing Journal*) (September 1963), 149–50, 154.