In Support of a No-exceptions Truth-telling Policy in Medicine

An odd standard has developed regarding doctors’ responsibility to tell the truth to their patients. Lying, or the act of deliberate deception, is viewed as unacceptable in normal relationships, and society demands that professionals in areas such as law and business tell the truth without exception. However, it is often expected that doctors will lie to their patients, or at least deliberately withhold information from them.¹ The rationale behind this expectation is usually the belief that, for some cases in medicine, lying will lead to a preferential outcome, which is usually defined in terms of the mental state of the patient being lied to. There are a variety of views and justifications regarding this issue; I will respond specifically to the arguments Roger Higgs presents in his paper “On Telling Patients the Truth.” Higgs argues against a number of justifications for lying to patients but concludes, somewhat vaguely, that in “some circumstances” doctors are “probably” not required to tell the truth (512). Using some of the points Higgs’ argues for in his paper, I intend to forgo his conclusion and instead argue the stronger point that doctors are never justified in lying to their patients. My argument will rest on utilitarian (rather than non-consequentialist) grounds, which is a point that I will address later.

Why is it that doctors are often held to a less rigorous standard with respect to truth-telling? The reason seems to be that there exist cases in medicine where the only effect of lying (or truth-telling) is on the mental state of the patient being lied to; in other words, it is thought that in some cases there will be no further repercussions beyond this effect. If accurate, this explanation makes it clear why lying is not at all permissible in other professions such as law and business. Indeed, in these professions it is abundantly clear that lying to an individual can have many repercussions beyond the effect to the mental state of the individual being lied to. In medicine, it would seem that if the only consequences of a lie are reflected in the mental state of

¹ In this paper, I equate lying and deliberate withholding of information, as both are acts of deliberate deception.
the person being lied to, a lie is justified if it results in a preferable mental state in that person. The position I will defend is that first, it is often the case that a lie will actually affect a patient negatively, and second, that there are actually no medical situations in which a policy permitting lying will affect only the mental state of the person being lied to. Rather, there will always be undesirable wider-scale repercussions that offset any possible benefits.

In order to show that doctors are never justified in lying to their patients, I will defend two main points: (1) that lying in general, and especially a policy stating that it is generally permissible for doctors to lie, is undesirable, and (2) that there are no exceptions, or cases in which a policy approving of lying (in these cases only) would be preferable. The first point is not difficult to defend at all; in fact, it seems almost to be the moral default position. It is commonly agreed that lying, in general, is wrong. A prominent moral objection to lying is that it robs the deceived person of his or her autonomy; after all, a person cannot make an informed, autonomous decision with incorrect information. In the case of medicine, it seems clear that in most cases, it would be seriously wrong for doctors to lie to their patients. No one would want a doctor to lie to him or her about the detection of a treatable disease or the potential side effects of a treatment, for example. It is clear that in these cases as well as in many others, the utility of the lied-to patient would be adversely affected. Thus, in the common cases lying is seen as wrong; it is in the uncommon cases—the supposed exceptions—that controversy arises. Higgs argues that most of these supposed exceptions are actually non-exceptional, but he does not go as far as to say that there are no exceptions, which is the point that I intend to make. The next stage of my argument will therefore be to outline the ways in which a specific case may be exceptional and then to show for each instance why this is actually not the case.

An example commonly used by opponents of a no-exceptions truth-telling policy is that of a patient who has been diagnosed with a terminal disease. In this type of example, a doctor has
just diagnosed a patient as having a terminal disease, but the patient has no idea that this is the case. The doctor knows that the patient has, for example, only six months to live and that treatment is impossible. Should the patient be informed that he or she has this disease? The problem here is that on first glance it may seem that telling the patient the truth will do only harm and no good. It seems possible, after all, that the patient could live out the final six months of his or her life happily if he or she remained uninformed of the disease.

Some objectors to lying to terminally ill patients claim that lying does not respect the patients’ autonomy, or that adopting a policy of lying would be overly paternalistic. I will not be relying on such arguments since, as I stated earlier, my argument rests on utilitarian grounds; my aim is instead to point out the unforeseen negative consequences of a policy permitting lying. First of all, it remains to be seen whether the overall utility of the patient affected will actually be maximized if a policy of lying is adopted. While the patient may be initially happier if he or she is not told, eventually the reality of the disease will become unavoidably obvious: it will at some point become clear to the patient that death is imminent. If at this point, the doctor admits that he or she lied to the patient earlier, the effect could very well be much worse than if the doctor had told the truth to begin with. The patient—and his or her family—may feel angry at the doctor, and, depending on the circumstances, as if the patient’s last six months of life were wasted. If, on the other hand, the doctor does not admit to the patient that the terminal disease was known all along, the patient will most likely strongly suspect the doctor of having lied anyway. The reasoning for this claim goes as follows: if an official policy is adopted stating that it is permissible for doctors to lie to patients with terminal diseases, keeping non-doctors uninformed of the existence of this policy will almost certainly prove impossible. If the general public does know about the institution of such a policy, the honesty of doctors regarding terminal disease diagnoses (or namely non-diagnoses) will continually be brought into question. Thus, a patient
learning of his or her terminal disease a week, say, before death, will automatically suspect his or her doctor of having lied (even if the doctor actually had not known about the disease previously!). And I have stated above what the consequences of such knowledge (or suspicion) may be. Thus, it is not at all clear that deception will generate the greatest possible outcome for a terminally ill patient.

I have alluded in the previous discussion to another problem with a policy promoting lying to terminally ill patients. If it is known that such a policy exists (and this seems unavoidably to be the case), it is clear that more people than only the terminally ill patients will be affected. After all, anyone may be terminally ill if doctors always lie in such situations! This sort of uncertainty is bound to be frustrating to many people, especially to those whose symptoms seem to suggest illness. Furthermore, as Higgs suggests in his paper, a policy promoting lying will likely erode general public trust in the field of medicine. If it is known doctors will willingly lie in some cases, to what extent should they be trusted in general? For that matter, why even come to a doctor if one expects to be lied to? It is clear that such worries will have a deleterious effect on the utility of the general population. Thus, although in the individual case, it may seem that lying affects only the patient being lied to, a policy permitting lying will unavoidable affect many, if not most, other people.

A somewhat more difficult example often raised is that of doctors using placebos, which are fake “medicines” used only for their positive psychological effects. It has been shown that patients who think they are receiving useful medical treatment will tend to do better than those receiving no treatment at all; thus, despite being fake, placebos do serve a positive purpose. Because placebos will not work if the patients taking them are not deceived into thinking the placebos are real medicine, it would seem that lying to patients is acceptable in such cases. Besides the fact that doctors lying about placebos may erode general trust in the medical
profession (as discussed earlier), the major problem with placebos is not with cases in which they are used, but instead with cases in which they are not used. If a general policy permitting placebos (and presumably the explanatory lie that must accompany their administration) is implemented, the effectiveness of all medicine, or at least all non-well-known medicine, will be brought into question. If it is known that doctors will administer and lie about placebos, how do I know that the medicine I am being given is not a placebo? Even though in the vast majority of cases no placebos will be used, this nagging doubt will likely prove inescapable for some patients. It seems that given the relatively low prevalence of placebos compared to working drugs or treatments, the suffering of those taking real medicine outweighs the benefits of a placebo-encouraging policy.

The final issue I will address is that of lying to patients who are either very young or in some way mentally handicapped. It is often thought that such individuals will receive only the benefits and none of the drawbacks of a policy permitting lying. So should we encourage doctors to lie to these patients, for example, when they are diagnosed with terminal diseases? I should first state that I will only consider situations in which the affected patient has some capability to understand what a doctor is telling him or her. A one-year-old or a severely mentally retarded person, for example, will likely not be able to grasp his or her situation at all; thus, the decision whether to lie or not in these cases seems somewhat trivial. A more interesting case is that of a (normal) six-year-old, who by all accounts should have some ability to understand the meaning of what a doctor tells him or her. Most people would probably agree that it would be a bad idea to tell a six-year-old directly that he or she is going to die, and an individual six-year-old’s utility is likely to be maximized in the case of non-full-disclosure. Furthermore, because it is hard to see how the greater population of six-year-olds will be negatively affected by a policy allowing lying to six-year-olds, it is more difficult to dismiss arguments in support of deception. However, there is one very important difference between a six-year-old patient and an adult patient: the six-year-
old is not considered an autonomous individual, and thus cannot (and should not) make his or her own medical decisions. It is clear that the six-year-old’s parents should be told in the case of a terminal disease diagnosis, as they are the child’s caretakers and the ones making his or her medical decisions. (And the reasons for not lying provided previously for cases of terminal disease apply in the same way to the child’s parents in this case.) Thus, if we view the patient in the case of a six-year-old (or otherwise mentally incompetent individual) as the combination of the six-year-old and his or her parents (or caretakers), we see that lying is also impermissible in this case as well. Although it may be objected that this argument is purely semantic and that the child—the patient!—is still being lied to, there is a clear difference, as I have noted, between this case and a case involving an adult patient, namely that the relevant autonomy is not held by the six-year-old. Thus, it is my argument that it is possible to avoid disclosing information to the child in this case while still not lying, as long as the parents are fully informed.

My argument in support of a no-exceptions truth-telling policy for medicine has primarily consisted of responses to cases in which it is often thought that lying to patients is permissible (or even to be encouraged). This strategy stems from the fact that, as I noted earlier, the default moral position is that lying should be avoided. Though it may be the case that I have ignored some important situation in which lying is in fact permissible, I suspect that arguments similar to those I have put forth in this paper will apply in other situations. I hope to have shown that it is at the least very difficult to formulate a policy permitting lying that does not produce negative consequences vastly outweighing the positive ones.