find significant discrepancies on any of these points, you need to begin to develop resources to deal with them.

You will examine specific elements of these expectations in the remainder of this and other chapters. Keep in mind the conclusions you have reached in this section, for you should bring them to the issues to which the discussion now turns.

2 Information Exchange

2.1 Relationships

As background for discussions of information exchange in the DPR, consider the expectations and obligations for providing information in the following relationships.

2.1.1 Casual Encounters  You are flying home to visit your family. The person sitting next to you on the plane is a stranger, and is friendly. You chat casually from time to time, though you are both reading. When asked "what you do," you say only that you are "a student" and do not mention that you are in medical school. (Perhaps you are tired and not in the mood for the health history or the catalogue of gripes about doctors you know could follow your giving this information.) Then your neighbor calls your attention to a magazine advertisement for an acetaminophen tablet and asks, "I wonder if this stuff is really safer than aspirin? What do you think?"

How would you respond to this question? What is expected of you?

This stranger is clearly "making conversation." She may be genuinely interested in your opinion, which may influence her opinion on the matter. As a layperson herself (apparently), she has heard enough about this subject to have some concern about the relative safety of aspirin, and she assumes that you (whom she assumes to be a layperson) have been exposed to similar information. Her interest seems to be in hearing (1) something about what you have learned about this issue ("I have heard...") and/or (2) something about the impact this information has had on your own thinking about what pain reliever to take yourself ("I intend to keep taking my old reliable aspirin."). She would undoubtedly be shocked by either (3) an authoritative pronouncement from you without explanation (e.g., "Look, just ignore these 'scare pieces' in the popular press. Go ahead and take your aspirin and don't worry about a thing!") or (4) an elaborate explanation couched in scientific terminology.

If you give the sort of response she is expecting, your reply might have an influence on her thinking, but it will not be particularly great. She will consider what you say alongside what she has read and heard from others and, on that basis, she will make a decision.
Matters would be significantly different, however, if you responded: "As a matter of fact, I am a medical student, and I have just been going over the studies dealing with the comparative safety of aspirin and acetaminophen. I can tell you with assurance that..." Obviously, this would gain you a much greater influence on her decision. But it would not guarantee that she would follow your advice. For one thing, it makes a difference that you are a medical student, not a practicing physician (although, in fact, your knowledge base may be more extensive and more up-to-date than many physicians in practice). Second, you are not her physician, so the trust and reliance built into established physician-patient relationships does not exist, which affects the weight she will give to your response.

Let us carry this scenario further. Suppose that you do not reveal your background and dig into your medical knowledge for a detailed answer to her question. Further suppose she proceeds to make a choice, which might have been different if you had given detailed and convincing advice—and that this choice leads to a harmful result (e.g., she continues to take aspirin and a life-threatening hemorrhage develops).

Would it be appropriate to say that you were in any way responsible for this harm? Did you have any obligation to provide a detailed answer to her question? It would certainly be ethically wrong to give her an answer you knew to be false, but it is difficult to see how you have any obligation to give her detailed medical advice. It would probably be inappropriate to ask the questions whose answers you would need in order to give a response fitting the particularities of her physical condition. You would do her a service if you gave an answer drawn from your study of the issue, but you have no obligation to launch into a detailed recital of medical science.

A related issue is the respect for and authority of medical pronouncements that are regularly part of commercial advertising. (The epitome of this is the actor who formerly played the role of a kindly physician in a television series who now trades on that role to assure viewers of the health benefits of caffeine-free coffee). Here, even when the claims have some connection to medical information (which is not common), they are not specific enough to count as solid "medical advice." All too often the appeal to a medical basis for a claim is wholly unfounded. This is the fallacy of "appeal to authority," in which a figure who has attained a position of authority due to genuine achievements is used to lend credibility to claims that fall outside the arena of his expertise.

2.1.2 Friends You are "shooting the breeze" in a group with which you have maintained a close friendship since high school days. None of its members is in a field related to medicine. (Perhaps that is one reason you look them up periodically, for it is good to escape from the preoccupation with medical science shared
by your medical school friends.) One of them points out a billboard advertising an acetaminophen product and says to you, "Hey, Doc, is this stuff really safer to take than aspirin? What do you think?"

How would you respond to this question? What is expected of you?

Your friends may be interested in giving you a chance to "show off" your knowledge. They may be less interested in the content of your answer than in (1) the authoritative tone and/or (2) the impressive-sounding scientific terminology in which your explanation is couched.

However, you would be remiss if you launched into meaningless "double-talk" (unless you eventually made it clear to everybody around that you were doing so) because your friends undoubtedly do respect your knowledge and they might quote your answer to others or take it into account in making decisions about painkillers. However, if a bad result occurred (either from following advice given in this sort of casual situation or from your not having given a detailed answer), you could not really be held responsible, either legally or morally.

2.1.3 Patients  You are seeing a patient in the hospital outpatient clinic. After you have taken care of the presenting complaints and as the patient is gathering things to leave the examining room, he turns to you and asks, "Doctor, what is this I hear about XYZ (an acetaminophen product). Is that stuff really safer to take than aspirin?"

How would you respond to this question? What is expected of you?

This is a request for professional advice. This patient is likely to take your answer seriously, quote it to neighbors, and base his pain reliever purchases and administration habits on your response. The trust and reliance on your authority that is a component of the physician-patient relationship is present here.

However, it is your general knowledge of medical science being sought, not a diagnosis of any particularities of the patient's condition. (Although you would be wise to think through the patient's history to determine if there might be any special risk factors present.)

It is possible (but not probable) that this is more than a casual question. Sometimes the question asked at the examining room door as the patient is leaving is the primary reason that brought the patient in. If there is any indication that this might be the case here—that, for example, the patient is especially worried about this issue, or perhaps that he suspects that some harmful effects have occurred from taking one or the other pain reliever—then it might be good to bring him back into the examining room to explore the matter in detail.

However, it is more likely that the question is a casual one, asked for the purpose of settling doubts in the patient's own mind, or perhaps to settle an argument with a friend. Thus, a generalization is a sufficient response.

Let us carry this scenario further. Suppose this patient acted on the basis of your recommendation and a harmful result ensued. What would be your responsibility?
If there had been a specific contraindication in the patient's medical history you overlooked in formulating your advice, there might be legal liability. However, if no such contraindication had been revealed, you would probably not be expected to conduct further examination and tests to provide a specific basis for answering this question, and you probably would not be held legally responsible for a bad outcome that could have been prevented only by further examination and tests. Moral responsibility is congruent with legal responsibility in this situation.

2.1.4 High-Risk Patients  A patient you are treating for nasal polyps asks whether it would be safer to take acetaminophen rather than aspirin for frequent headaches.

How would you respond? What is expected of you?

Here a full-scale medical judgment is called for—general scientific information as well as the application of that information to the particularities of this patient's condition. There are higher stakes involved than in the other cases we have looked at because there are significant risk factors present in this case. You would be well-advised to review the patient's medical record carefully and draw on the full range of your knowledge of medical science in formulating a reply.

2.2 Obligations

Some fundamental principles about moral obligations regarding information exchange can be derived from the foregoing scenarios:

1. There is a general moral obligation not to give misinformation or tell a direct lie. This applies in dealings with everybody.

2. There is no general moral obligation to tell "the whole truth," i.e., to give to others information we happen to possess, even if what we could tell them would be beneficial to them. It might be commendable to assist others in this way, but this seems more like a matter of "Good Samaritanism" or action "above and beyond the call of duty" rather than a moral obligation.

3. A moral obligation arises to provide beneficial information in the physician-patient relationship. This is an aspect of the duty of care, recognizing that providing information is a significant element of medical treatment. This includes especially information about things the patient could do to speed recovery and/or to prevent a recurrence of the condition being treated, but it also includes providing information about the rationale underlying recommendations for treatment, since this may be the best way to impress on the patient the importance of following these recommendations.

4. Furthermore, the obligation to provide care includes an obligation to a) acquire the information needed to provide adequate care, and then b) share this information with the patient for his benefit. If the stakes are
high, this may require elaborate steps (e.g., high-technology diagnostic tests
and/or an extensive literature search) to acquire the needed information.
5. You will see in the next section that the legal and moral requirement of
informed consent imposes an obligation on the physician to impart infor-
mation to the patient.

These principles do not settle the matter of information exchange, however. A
number of questions are still left unanswered.
1. What are the obligations of the patient to give information to physicians?
2. What (if any) are the limits of the obligation to provide information to
patients? Must a physician impart "the truth, the whole truth, and nothing
but the truth"?
3. What are the moral guidelines about imparting information to persons other
than the patient? 9

2.3 Fulfilling These Obligations

Consider a concrete example of the transactions of information exchange. Many
people think of this as occurring exclusively in the phase of clinical interaction that
was earlier called "Recommendation and Negotiation" (Section 1.2.4.B.2). 10
However, much of the most important information exchange takes place in the part
of the clinical phase that was earlier called "clinical method" (Section 1.2.4.B.1),
so let us begin there.

Lynn Languish 11 sits on the edge of the examining table when you enter the
examining room. She is a well-groomed woman in her mid-thirties. She appears
not to be in acute distress at the moment, but that she is worried is obvious.
She explains her reason for coming in: "The other day, I noticed this lump in
my armpit. When it did not go away after several days, I got concerned about it. I
would like you to examine it and tell me whether it is anything to worry about."

Your examination reveals a small, firm node in the axilla. You do a thorough
breast exam, but no mass is palpable and no dimpling is observed. You question
her about a history of infectious diseases or localized infections, but she reports no
signs of anything along these lines.

What should you do next? (Pursuing details of the clinical work-up is beyond the
scope of this book. The focus here is on the ethical dimensions of practice.
However, the ethical dimensions cannot be separated from the clinical, so you
should think through the clinical dimensions as you are guided to address the
ethical issues here.)

9. Discussion of this issue is found in Section 4 of this chapter.
10. This component of information exchange is linked closely with the legal and ethical requirement
of informed consent, which is the subject of Section 3 of this chapter.
11. See Section 1.2.1.B for the initial scene in this patient's story.
More central to the ethical issues, what should you say to Lynn at this point? Look over the list of items below. For each item,

1. Consider whether you would tell this to Lynn at this time.
2. Consider why you would or would not tell her this.
3. Consider whether you would express it to her in *just this way*. If not, indicate in the space provided *how* you would put it.
4. Consider *in what order* you would explain these items. Number them in the order in which you would proceed.

<table>
<thead>
<tr>
<th>Tell Lynn?</th>
<th>In what order?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Y / N</strong></td>
<td>Say, &quot;&quot;The nodes might be a sign of cancer of the breast.&quot;&quot;</td>
</tr>
<tr>
<td></td>
<td>Why or why not?</td>
</tr>
<tr>
<td><strong>Y / N</strong></td>
<td>Say, &quot;&quot;The nodes might be a sign of AIDS.&quot;&quot;</td>
</tr>
<tr>
<td></td>
<td>Why or why not?</td>
</tr>
<tr>
<td><strong>Y / N</strong></td>
<td>Say, &quot;&quot;I don't think this is anything serious.&quot;&quot;</td>
</tr>
<tr>
<td></td>
<td>Why or why not?</td>
</tr>
<tr>
<td><strong>Y / N</strong></td>
<td>Say, &quot;&quot;This could be something serious.&quot;&quot;</td>
</tr>
<tr>
<td></td>
<td>Why or why not?</td>
</tr>
<tr>
<td><strong>Y / N</strong></td>
<td>Say, &quot;&quot;This <em>could not possibly</em> be anything serious.&quot;&quot;</td>
</tr>
<tr>
<td></td>
<td>Why or why not?</td>
</tr>
<tr>
<td><strong>Y / N</strong></td>
<td>Say, &quot;&quot;I am sure this is <em>not</em> cancer.&quot;&quot;</td>
</tr>
<tr>
<td></td>
<td>Why or why not?</td>
</tr>
<tr>
<td><strong>Y / N</strong></td>
<td>Say, &quot;&quot;This is nothing to worry about.&quot;&quot;</td>
</tr>
<tr>
<td></td>
<td>Why or why not?</td>
</tr>
<tr>
<td><strong>Y / N</strong></td>
<td>Say, &quot;&quot;I'm not sure what caused the swelling in this node.&quot;&quot;</td>
</tr>
<tr>
<td></td>
<td>Why or why not?</td>
</tr>
<tr>
<td><strong>Y / N</strong></td>
<td>Say, &quot;&quot;We need to do some tests to find out the cause.&quot;&quot;</td>
</tr>
<tr>
<td></td>
<td>Why or why not?</td>
</tr>
</tbody>
</table>
Y / N Describe the risks and discomforts of the test(s). 
Why or why not? 
How to put it: 

Y / N Say, "Here's how much the test(s) will cost." 
Why or why not? 
How to put it: 

Y / N Ask, "What do you think the problem is?" 
Why or why not? 
How to put it: 

ADD: Say, 
Why add this? 

ADD: Say, 
Why add this? 

ADD: Say, 
Why add this? 

ADD: Say, 
Why add this? 

2.3.1 "The Truth" This discussion takes a "Golden Rule" approach to the issue of information exchange. It begins by considering examples of miscommunication by the patient and asks you to examine your reaction to these; on that basis, you should consider the parallels between these incidents and certain practices by physicians.

A. Patient Suppose you discovered that Lynn had lied to you in her account of the node.Suppose she told you that it was extremely tender and painful (perhaps even feigning a wince or a groan when you palpated it), whereas, in fact, it was not painful at all. Perhaps she said this hoping you would prescribe pain medication (which she enjoys using when it is available, although she does not seek it on a regular basis). If you discovered this subterfuge, you would no doubt be angry and disappointed to learn that a patient had told you a direct lie. You expect patients to tell you the truth when you ask them questions. You feel that you have a right to the information and a right to be trusted with the information. You are employing your diagnostic skills for her benefit, but a lie subverts this goal.

Would your reaction change if you discovered that the reason for her lie was that she had heard that nontender lumps are a sign of cancer and she could not bring herself to face the possibility that this might be cancer? Think about this question for a minute before you continue. A sensitive reaction would include empathy for her fear, but some frustration and disappointment is likely to result in even the most sympathetic clinician, for her misinformation could steer you down the
wrong diagnostic trail entirely. In addition, her failure to communicate fully with you shows that (at some level, perhaps subconscious) she is not willing to be open with you and trust you to handle her fears sensitively and assist her in dealing with them. Even with the most favorable interpretation, her lying shows something is lacking in the relationship between you and her. As indicated in Section 1.2.2, honesty and openness are expected of patients.

Of course, some kinds of patients’ lies are so common as to be expected; thus they are treated as part of the clinical data. Patients’ reports about how much they smoke or drink are routinely “corrected” upwards. Or patients present with a complaint so transparent in its falsity that it must be regarded as a disguised call for help, and the clinician must explore the real reason for their visits. For example, a patient may come to a hospital emergency room repeatedly in a highly intoxicated state complaining of “chest pains” and deny that he has been drinking heavily, although his behavior and the alcohol on his breath clearly show he is intoxicated. Sensitive and patient exploration with the patient might lead him to agree that he is really there seeking help with his drinking problem.

However, the typical reaction of physicians to these situations demonstrates that they are not free of ethical issues. Patients may be excused (at least to some extent) from moral condemnation for this behavior on grounds of their impairment. The physician may be willing to “play the little game” in the interest of helping patients overcome the problems that prompted this behavior. However, the negative attitudes these patients arouse may be due, in part, to a recognition of the questionable ethical character of these actions.

B. Physician Of course, patients have a similar expectation of you. A serious breakdown of Lynn’s trust in you would occur if she discovered you had told her an outright lie—for example, if she discovered that you were aware that there were life-threatening possibilities among the differential diagnoses at the time you told her that “It could not possibly be anything serious.”

And even if she did not discover your lie outright, it is likely that your calculations to maintain the deception would affect the nature of your interactions with her. (For example, you would be forced to try to act casual about the importance of carrying out additional tests, although you would feel a certain urgency about this.) This is likely to produce significant impairment of your relationship at a subconscious level, even if she were not aware of the cause. This result could be avoided only if either you were so adept at lying that no clues at all of your artifice were communicated, or you were so emotionally “cold” toward the patient that she could not detect any difference between an open and honest communication and one clouded by artifice. The former of these requires morally questionable skills, and the latter is hardly to be recommended as a way of interacting with patients. Thus, it can almost never be justified to tell a patient an outright lie.
B.1 Half-Truths  Is there a significant moral difference between an outright, "bald-faced" lie and other forms of expression that might mislead? Consider this question for yourself in connection with the following examples. Do you see a significant moral difference between these responses to Lynn Languish?

1. Telling her "This could not possibly be anything serious," when you are well aware that life-threatening conditions are included among the differential diagnoses.

2. Telling her "I am quite sure that this node is not a sign of cancer of the breast" when you are pretty sure it is not, but you are not really "quite sure."

3. Telling her "I don't think this is anything to worry about" and reassuring her that you would let her know if you had reason to believe that this was cancer
   a. when you mean that there is no point in her worrying about this now since there will be plenty of time for worry later if it turns out to be cancer,
   b. but you know that she is likely to take you to mean that you are sure that it is not cancer.

4. Telling her that you are 95% sure this is not cancer
   a. because you feel you cannot honestly give any greater assurance than this on the basis of the evidence available so far,
   b. although you know she is so worried about cancer that she will not be calmed unless you tell her that you are 100% certain that it is not cancer.

All of these have the same outcome: the patient comes to believe something the physician considers to be false or, at least, unsupported by the available evidence. Only the first, however, is an outright lie. (Following many ethical theorists, we would define a "lie" as a matter of saying something that one believes to be false.) None of the other examples involve this, strictly speaking. However, responses 2 and 3 are forms of deception, for they involve deliberately causing the patient to believe something the physician regards as false or unsupported. Furthermore, all three responses are contrary to the usual expectation of patients. Indeed, the deceptions succeed (particularly in example 3) only because the patient presupposes that she will be told the truth. So, even if there are moral gradations among these three responses, all raise serious ethical questions. 12

Response 4 is significantly different from the others. Here the physician cannot be said to be deliberately deceiving the patient, even though the result may still be that the patient comes to believe something the physician regards as almost certainly false. The ethical issue raised by this example is the value and importance of truth in itself. Which is more important for the physician: to be honest or to offer

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12. For further discussion of these questions, see Bok (1978), especially Chapter XV: "Lies to the Sick and Dying".
reassurance? The AMA Principles of Medical Ethics favors the former. Section 2 says: "A physician shall deal honestly with patients. . . ." 13

2.3.2 "The Whole Truth" How much should physicians tell patients? Should patients be informed of all your suspicions? Should you share all your uncertainties? If not, where is the line drawn between what should and what should not be communicated? Look over your responses to the exercise in Section 2.3 and consider what answer to these questions your choices presupposed. Again, let us approach discussion of these questions by first considering your expectations about patients providing information to you.

A. Patient

A.1 Deliberate Omission Suppose you found that Lynn had not lied directly but had withheld certain information. (NOTE: We are changing the hypothesis here. Forget about the earlier scenario in which she told a direct lie.) Suppose that she had deliberately refrained from telling you about a bit of bloody nipple discharge she had noticed a few days ago, even though she was (vaguely) aware that this information might be directly relevant to the diagnosis. (Why did she withhold this information? She thought the discharge might be the result of some aggressive sexual play her husband had engaged in, and she felt too embarrassed to tell you about it.) What would be your reaction if you learned she had withheld this information?

A.2 Relevance Unrecognized The situation might be different if the omission were not deliberate. Suppose it became clear that she had failed to recognize this information was relevant to the diagnostic puzzle. It is not that she was trying to mislead you by withholding this information, she merely failed to recognize the importance of bringing it up (and was acutely embarrassed to mention it). What would be your reaction?

A.3 Information Overlooked A still different situation results if the information is not provided because the patient failed to obtain it: "Have you had any dark stools or frank rectal bleeding?" "I don't know. I haven't looked." What would be your reaction here? Do you expect "the whole truth" from patients?

B. Physician Similarly, do patients expect "the whole truth" from their physician? There are indications that physicians do not always give full information. In a poll conducted by Louis Harris and Associates for the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral

13. For the full text of the AMA Principles, see Chapter 2, Section 1.2.
Research (1982b, 17-316), physicians reported the following information-withholding practices (Table 1-1):

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Information Is Withheld About Diagnosis or Prognosis</th>
<th>Treatment Risks and Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a day</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Once a week</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Once a month</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Few times a year</td>
<td>32%</td>
<td>24%</td>
</tr>
<tr>
<td>Almost never</td>
<td>46%</td>
<td>57%</td>
</tr>
</tbody>
</table>

[President’s Commission (1982a, 97).]

Approximately one-fifth of physicians admit to withholding key information from patients at least once a month.

One situation corresponding to A.2 in the description of patient miscommunications occurs when the physician omits an item of information because he or she does not recognize that it might be important to the patient. This marks a failure to ascertain the value system of the patient. More serious are situations corresponding to A.1: deliberately withholding information you know would be relevant to the patient’s thinking. What sorts of reasons might lead one to take such a step? In the following list mark the items you have found yourself exemplifying in your own reasoning in the past, or can envision yourself exemplifying in the future:

1. To avoid the discomfort the patient’s reaction is likely to cause you.
2. “It would take too long to explain it all.”
3. Not wanting to have to get an investigational work-up underway this close to your vacation.
4. Not disclosing how remote the probabilities are for certain frightening but extremely remote possibilities (e.g., AIDS), in hopes of luring the patient into an expensive diagnostic work-up to rule these out.
5. Wanting to wait until you are sure before giving her information of this magnitude.
6. Because the family urged you not to tell.
7. Not wanting to cause her needless anxiety.
8. Not wanting to take the time to deal with the patient’s ensuing depression.
9. Not wanting to deprive her of hope.
10. Because you judge that giving her this information might prompt her to forego needed therapy.
11. Because you judge that she will not be able to understand the information.

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14. This poll involved standard opinion survey methods. Interviews were completed with a national sample of 805 physicians and a national cross section of 1251 adults.
12. Because you think she is not mentally competent to make any sound use of the information.

13. Because you think that although she may be competent now, she will not be able to make competent use of the information once it is presented to her, because her mental state is such that hearing this information would destroy her ability to make competent decisions on the matter.

14. Because you think her reaction would be irrational.

15. Because you are convinced that she really doesn't want to know.

16. Because you think she probably already knows.

The professional community has not been silent on this issue. Consider the following statement by the Judicial Council of the American Medical Association (1984, 29–30):

8.07 Informed Consent. The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. Informed consent is a basic social policy for which exceptions are permitted (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment. (I, II, III, IV, V)

Let us analyze the reasons cited for withholding information in the light of this statement and other moral considerations.

1. To avoid the discomfort the patient’s reaction is likely to cause you.

The first rationale for withholding information is likely to operate at the level of unacknowledged motivation rather than as an explicit reason. Surely no one would seriously deny that if the patient’s best interests were served by receiving this information, a physician’s obligations would include accepting any personal discomfort involved in presenting it to her.

However, even though it is theoretically indefensible, this consideration may continue to influence unconscious motivation. In particular cases, you should examine your own motives to be sure this element is not a determining factor in your decision to withhold information.

2. "It would take too long to explain it all."

This rationale functions much like the first, and it too can be readily seen as unjustified when stated explicitly. Allocation of one's time is a necessity, but it is not appropriate to neglect important needs of patients in the process. If it is
beneficial to the patient to receive this explanation (and it is argued below that it generally is), you have an obligation to find the time to provide it.

3. **Not wanting to have to get an investigational work-up underway this close to your vacation.**

The lack of justification for this consideration is equally obvious when it is articulated openly. Physicians certainly have a moral right to meet their own needs for relaxation and relief from vocational stresses, but they have the obligation to see that this does not interfere with meeting the needs of their patients. If the work-up cannot be completed before vacation, then some appropriate referral should be arranged to ensure that the dangerous possibilities are expeditiously pursued, and either ruled out or confirmed and treatment initiated.

4. **Not disclosing how remote the probabilities are for certain frightening but extremely remote possibilities (e.g., AIDS), in hopes of luring the patient into an expensive diagnostic work-up to rule these out.**

This clearly would be a blatantly unethical practice. The Judicial Council of the AMA (1984, 11) condemns it in these terms:

2.16 **Unnecessary Services.** It is unethical for a physician to provide or prescribe unnecessary services or unnecessary ancillary facilities (II, VII).

Only your own self-scrutiny, however, can reveal the extent to which improper economic considerations are motivating factors in particular decisions.

5. **Wanting to wait until you are sure before giving her information of this magnitude.**

The question to ask yourself, if you are persuaded by this rationale, is whether this policy is consistent with your practice regarding other sorts of information. Do you, for example, wait until you are certain before giving a patient indications about the prospect of good news, e.g., telling a couple working at pregnancy for some time that it appears that they have finally succeeded?

Psychologists describe the value of "preparatory worry" as a mechanism for coming to grips with bad news. Thus it seems that some preliminary indications, at least, of negative possibilities should be communicated.

6. **Because the family urged you not to tell.**

A recent poll of public opinion showed that nearly half of those surveyed (49%) thought it would be justified for a physician to withhold information at the request of the family; and 8% reported having made such a request of a physician regarding a member of their own family (President’s Commission 1982a, 98). Furthermore, 21% of physicians polled reported that the wishes of patients’ families were the most common reason for them to withhold information (President’s Commission 1982a, 96–97). However, the Commission hastens to point out: "There is no
recognition in law for withholding information from patients at the request of a family member’’ (President’s Commission 1982a, 98–99, note 41).

7. Not wanting to cause her needless anxiety.

A French oncologist forcefully states a form of this view concerning revealing a diagnosis of cancer:

For many complex reasons, Western man has a deep-seated conviction that cancer is the sickness that can never be cured. . . . To say to a patient “You have a cancer” is to say much more than “You have a serious disease”—even, sometimes, more than “You have a disease that may be fatal.” . . . Doctors have always felt this, and up until now the vast majority of them have refused to tell the naked truth. As everyone knows, they are subject to all sorts of pressures. They are even accused of robbing their patients of their deaths. (Israel 1978, 155–156)

In contrast, the President’s Commission (1982a, 99) reports:

There is very little empirical evidence to indicate whether and in what ways information can be harmful. Clearly there is a need to define “harmful” or “negative” consequences better and to distinguish between situational anxiety (caused by illness or hospitalization) and anxiety resulting from information. In addition, the mere fact that some information may be “upsetting” in and of itself does not justify withholding information.

Similarly, Bok (1978, 247) reports:

The damages associated with the disclosure of sad news or risks are rarer than physicians believe; and the benefits which result from being informed are more substantial, even measurably so. Pain is tolerated more easily, recovery from surgery is quicker and cooperation with therapy is greatly improved. The attitude that “what you don’t know won’t hurt you” is proving unrealistic; it is what patients do not know but vaguely suspect that causes them corrosive worry.

Furthermore, this reaction may result from a short-sighted view of the consequences of receiving unsettling information. Although there is little doubt that the immediate result will be a degree of unhappiness and anxiety, it may be possible (with counseling and support) for patients to move through this and other negative reactions to a more positive accommodation with their life prospects. It may even be possible for them to come to an active “acceptance” of their situation.

8. Not wanting to take the time to deal with the patient’s ensuing depression.

Of course, to support the patient through these negative aspects or stages of accommodation requires time, skill, and compassion. And, as discussed in Chapter 3, these aspects of care are often devalued because they fall away from “the moral center” of medicine. However, we have already seen in Section 1.2.4.C that these “extraclinical elements” have an importance to patients equal to (or, in some situations, greater than) the clinical aspects of treatment; thus they
must be provided as a part of adequate care. A team approach, in which nurses, medical social workers, and other appropriate professionals cooperate to help the patient work through these reactions, can lighten the burden of time and energy for the physician.

9. Not wanting to deprive her of hope.

This is undeniably an appropriate goal, but its realization depends more on how information is imparted than on whether it is shared. A harsh truth, blurted out in a clumsy way after the diagnosis has been fully confirmed and without any prior hint of serious possibilities is more likely to engender hopelessness than gradually making the patient aware of the degree of seriousness of the condition as it is ascertained through the diagnostic process.

Hope means different things to the patient at different stages of terminal illness. The physician probably should never close the door entirely on the remote possibility of recovery. But for many patients in advanced stages of illness, hope becomes focused on alleviation of pain and isolation rather than on prospects for recovery. Hence assurances that you and other caregivers will continue to be with the patient and that you will continue measures to maintain comfort for him or her may be more reassuring than groundless promises of recovery.

10. Because you judge that giving her this information might prompt her to forego needed therapy.

In the poll of the public, only a minority (38%) thought it justified for a physician to withhold information from a patient on the grounds that it might make the patient unwilling to undergo treatment the physician thinks is necessary (President's Commission 1982a, 98). The policy statement by the AMA Judicial Council, quoted a few pages back, explicitly condemns this justification and identifies what is objectionable about it—it is paternalistic.

11. Because you judge that she will not be able to understand the information.

Twenty-eight percent of physicians polled listed the patient’s inability to understand the information as the most common reason for withholding it (President’s Commission 1982a, 96–97). However, rather than a justification for not providing information, this should be viewed as imposing an additional task on the physician, i.e., instructing the patient about the meaning of the information. In some cases, it may not be easy to educate patients to the level of comprehension necessary for informed consent, but if it is accomplished, it may have salutary effects on their cooperation with treatment and their psychological outlook.

12. Because you think she is not mentally competent to make any sound use of the information.
Just as there is no obligation to initiate futile treatments, so also there can be no obligation to provide information that cannot be used by the recipient. In the discussion of informed consent in the next section of this chapter, determinations of incompetency and procedures for decision making in this situation will be addressed.

13. Because you think that, even though she may be competent now she will not be able to make competent use of the information once it is presented to her, because her mental state is such that hearing this information would destroy her ability to make competent decisions on the matter.

The chief difficulty here, as in item 12, is in evaluating the evidence on which this prediction is based. Can you have sufficient assurance that you know how the patient is likely to react in this situation? Perhaps she has strengths of which you are unaware. Furthermore, even if her initial reaction is to "fall apart," perhaps (with supportive counseling) she will be able to "pull herself together" in time to take an active part in decision making.

You must guard against tendencies to overrate the dangers here. Be sure that you are not reading into the situation either (1) elements of your own reaction to such a prospect, (2) anecdotal evidence from one or a few uncharacteristic cases, or (3) your own unwillingness to engage in the needed counseling (see item 8).

14. Because you think her reaction would be irrational.

The danger here is in imposing on the patient your own judgments of what is rational and irrational. As the policy statement of the AMA Judicial Council reminds us, "rational, informed patients should not be expected to act uniformly, even under similar circumstances." If the patient does react in a way you regard as irrational, this may be negotiated in the process of doctor-patient accommodation (described in Section 1.2.4.B.2 and Section 3).

15. Because you are convinced that she really doesn't want to know.

It is tempting to draw this conclusion hastily from indications of denial or resistance on the part of the patient. However, this may be only one side of an ambivalent attitude, and the dominant wish of the patient may be to face the truth. Paradoxically, the claim that the patient does not want to know is usually stated in association with the claim that the patient already knows, which is addressed in the following item.

15. See Chapter 4 below for a discussion of this issue.
16. For an example of how a strong case against truth telling is built upon one dramatic anecdote, see Collins (1927).
16. *Because you think she probably already knows.*

Again, Israel (1978, 156–157) puts this issue forcefully:

We must also add to this debate another aspect that’s often forgotten: There are an infinite number of patients who, without ever admitting it to others or to themselves, “know.” Something in them knows. Yet for a variety of reasons they don’t seek to clarify the situation. They don’t speak of it to their family. They don’t ask their doctor about it. There is, after all, in reply to the advocates of truth at any price, one fact that must be emphasized: the patient very seldom asks for the truth. He undergoes all sorts of treatments, sees his condition fluctuate, is surrounded by menacing problems, and asks nothing. Often he even adopts a complex strategy, proposing explanations and diagnoses first, so that the doctor won’t be tempted to supply his own. Is the doctor supposed to break down this resistance and, in the name of the intellectual constructs of persons who are not suffering, to destroy the defenses of those who are? What is the meaning of these defenses? That the patient has a doubt, a doubt he can encapsulate and repress if given the chance, and that he desperately wants to repress. In such a situation, with such a defense mechanism at work, I have never felt I had the right to tell the truth, and I am prepared to defend that position against the criticisms of my contemporaries.

There are several comments to be made about this. First, a “chicken-and-egg” problem arises in interpreting these situations: Israel assumes that patients develop these defense mechanisms for reasons of their own, and thus his attitude toward withholding information stems from a desire to respect these preexisting psychological needs. However, interviews with cancer patients (including children) reveal that their perception is often that things work the other way around. They sense that the physician (and often the family as well) “don’t want to talk about it”; thus they develop veiled forms of communication as a way to prevent disruption of relationships vital to them.

Furthermore, even when patients independently develop this sort of defense mechanism, it is questionable whether they ought to be supported in such a reaction of denial. What Israel derides as “intellectual constructs of persons who are not suffering” includes some careful psychological analysis drawn from observation of persons who are suffering, as well as some moral analysis of these situations. Many psychologists hold that the psychic energy expended in maintaining a defense of denial is so great as to make it counterproductive and thus that the suffering of the patient is minimized in the long run if he is guided to face the truth and helped to deal with its emotional impact in a more open way. Similarly, moral analysis stresses the value of honesty in relationships, as well as in one’s self-understanding.

Finally, even if we grant that this defense mechanism should be supported on some occasions, there is a danger of overrating its prevalence due to our desire to avoid facing the unpleasant emotional reactions likely to result from working past denial. But this brings us full circle, back to the first rationale on this list.
2.3.3 "Nothing But The Truth" Of course, both patients and physicians communicate more than "the truth" or "the bare facts" to each other. Patients not only impart the facts about their experience of dis-ease, they convey their interpretations of what it means to them and their worries about it. The sensitive physician listens to this part of the patient's story no less carefully than the details that have direct clinical relevance, because it is upon these that one builds both the "recommendation and negotiation" phase of the physician-patient accommodation and the comforting aspect of patient care.

Similarly, physicians convey more than "the truth," especially in their role as comforters. Patients draw clues from the physician's air of confidence and concern. Such clues make an important difference in their mental attitude toward their bout with illness. These aspects of communication are as fraught with moral implications as the technical tasks of arriving at the diagnosis and formulating plans for treatment, and thus they deserve as much care in planning.

2.4 Placebos and the Placebo Effect

Truth is also an issue in the use of placebos. The use of chemically inert or ineffective substances as medications with the expectation that they will have effect through the power of suggestion (Leslie 1954) also involves deception. Even if an outright lie is avoided, e.g., by saying something carefully worded, such as, "I am going to give you a substance that has been proven effective in helping people in your situation" (which is not, strictly speaking, false), it is still a matter of deception. The statement and the substance have effect only because the patient believes that the substance is chemically therapeutic.

In addition to the fundamental objection to deception in a therapeutic relationship, there is further difficulty with the use of placebos in that the power of suggestion may be too effective: (1) Placebos may mask organic conditions in some cases. Studies suggest that some patients genuinely cease to feel the pain of organic conditions such as a myocardial infarction when given assurance that a placebo will relieve the pain. (2) They may cause serious side effects. The full range of side effects of potent medications have been reported from placebos, including such "objective" manifestations as skin rash, diarrhea, urticaria, and angioneurotic edema (Leslie 1954).

The situation is not much different, in moral terms, if a subtherapeutic dose of an active drug is substituted for an inert substance. If the physician believes that the medication will not be chemically effective but makes use of the patient's belief in its effectiveness through the power of suggestion, a form of deception is still the result. Of course, it is possible that the chemical properties of the medication contribute to the effect; but if the physician does not believe this will occur and leads the patient to believe it, a form of deception has occurred.
2.4.1 The Placebo Effect  Matters are different morally, however, in uses of the power of suggestion in combination with chemically effective regimens. If a physician attempts to ensure or enhance the effectiveness of a chemically potent medication she has prescribed by stating an endorsement of it in a confident tone ("I believe you will get relief with this."), no deception is involved. The physician is merely conveying to the patient something she believes (or has solid reason to hope) to be the case. This may amount to "manipulation" of the patient, but not in a deceptive way. Indeed, it is not clear that such artifice in a relationship is morally objectionable. A suitor dresses in his best clothes and employs his best manners when calling on his sweetheart to evoke a favorable response from her; we do not object and insist that he has an obligation to wear his shabbiest clothes and use his worst manners (or even to wear ordinary clothes and use ordinary manners). A professional seeking to enhance the patient's confidence in a treatment regimen is doing no more than this—"putting the best face on" the situation. There is an obligation to warn the patient of possible side effects of the regimen, but this does not preclude presenting the recommendation in the most favorable light that is honestly possible.

2.5 Conclusions

There is much more that could be said about information exchange. Additional questions about it will be encountered later in this book, in connection with other specific issues. In particular, the "informed" part of informed consent involves this issue and will be the topic of the next section of this chapter. However, it is time now to summarize the discussion of this section, both as a basis for future sections of this book and for your independent thinking. Let us return to the exercise at the beginning of Section 2.3 and draw answers about what and how Lynn should be told about the possibilities.

2.5.1 What To Tell Lynn Initially  First, say "I am not sure what caused the swelling in this node." By sharing your uncertainty at this point with the patient, you help her to understand why additional tests ought to be run (to be proposed in the third step) and thus prepare her to accept this recommendation. This admission of uncertainty also introduces the possibility that the cause might be something serious, which she ought to recognize even though you are about to calm her concern about it markedly by reassuring her in the next step.

Second, say "I don't think this is anything serious." This statement is reassuring to the patient, but not in a way that fails to fit the facts. At this point, there are myriad diagnostic possibilities; most of them are relatively benign. There are, of course, several serious possibilities as well, and by phrasing the reassurance in a somewhat guarded way—"I don't think . . ."—this is communicated without undermining the reassuring general tone of the statement.
Third, say "We need to do some tests to find what caused the swelling." Explain the purpose and nature of the tests you propose to do. This is the next step in the process of clinical method, and it is important to enlist the patient’s cooperation.

Fourth, ask "What do you think it is?" This question can draw out additional clinical information. More important, it can elicit the patient’s chief worries, which you can address in your counseling and comforting role. An alternative way to phrase this is: "What is your biggest concern about what this really means?"

This approach is preferable to hastily reassuring patients on the basis of what you presume to be their chief concern, e.g., by saying: "I’m sure this is not cancer." Not only may this suggest a basis for worry that had not yet occurred to the patient, but the emotional impact of word "cancer" is so strong that (1) she may not hear anything else you tell her, including your reassurances, and (2) the possibility of cancer may become the exclusive focus of the patient’s recollection of the interchange.

2.5.2 "As Time Goes By" As the diagnostic process proceeds, Lynn should be given additional information as it becomes available. As the clinical trail leads decisively toward a diagnosis of breast cancer, for example, she can be prepared for this outcome by being introduced to the possibility in a gradually more explicit way. By the time the diagnosis is finally made, it will not be such a dramatic shock. She will have been prepared for the possibility, at least to some extent, by earlier discussions. This is not to deny that there still may be significant emotional impact to hearing a confirmed diagnosis, and steps should be planned to help her deal with this.

The difficult situation, for the approach proposed here, comes in cases in which the diagnosis was made abruptly and unexpectedly. This would not readily allow time for recommended gradual disclosure of information. However, (1) the same supportive counseling is required (indeed, even more so) in this situation; it can go a long way toward helping the patient cope with unwelcomed news. (2) Similarly, tact in phrasing the information is no less required in this situation. (3) Finally, the approach recommended permits withholding the harsher elements of "the whole truth" for a short time in the interest of maximizing the patient’s coping systems. Thus, for example, were it obvious from the first examination that Lynn has breast cancer, disclosing this news might be postponed for a day or two, until members of her family or close friends could be present to offer her support. You might schedule a further confirmatory test and ask her to bring appropriate other persons with her to hear the results. This request would indicate that something serious was involved, prompting some preparatory worry that would begin to get her ready for the news.