Medical Humanities Report

This Issue: Truth-telling, Autonomy and Beneficence **Winter, 1995**

Autonomy and Truth-Telling: The Therapeutic Lie

In this issue, the Medical Humanities Report asks three ethicists from The Center for Ethics and Humanities in the Life Sciences and a surgeon to comment on a case study presented by Dr. Howard Spiro of Yale. The cased study (paraphrased below) was presented at a conference "Placebo: Probing the Self-Healing Brain" held at Harvard University, December 8-10, 1994.

> *A patient is brought to the emergency room in impending shock. The diagnosis is laceration of the liver with internal bleeding. Emergency surgery is required, but your assessment, as the patient's personal physician who is called to the emergency room to see him, is that the chances for survival are quite slim. The patient is still conscious and alert as he is being wheeled down the hall to the operating room. Just as the cart is about to roll through the swinging doors he asks you, "Doc, am I going to make it?"*

In his analysis of the case, Dr. Spiro interprets physicians' reluctance to tell a reassuring "lie" to the patient as a sign of the excesses of an autonomy-based ethic. In contrast, most of our commentators are seem unwilling to accept Spiro's assumption that in this particular case the well-being of the patient conflicts with the value of autonomy. They raise the question of whether the patient's autonomy is always served by being told the literal truth.

Commentary One: Howard Brody, M.D., Ph.D.

Some case studies are offered to start discussion. This case seems designed to end discussion; at least, that was the effect that it had when I first heard it presented to an audience several years ago. After hearing it again recently, I was prompted to explore my reactions to the case in more depth. I conclude that the case ought, indeed, to prompt a more thorough discussion -- both of what should be done here and now, and also of what character traits physicians ought to cultivate in themselves.

(Brody continued on page 2)

When the case is offered to stop discussion, the point seems to be this: medical ethics used to worship the good of the patient and ignore questions of patients' rights and autonomy. We have now made respect for autonomy the centerpiece of ethics, and that has had some good results. But taking autonomy too seriously, to the exclusion of beneficence, risks creating a caricature of what medicine ought to be about. In the case example, physicians who do not say immediately and convincingly, "Yes, of course you are going to make it," betray the fact that they have been so seduced by an autonomy ethic as to, in effect, no longer be true physicians. They are now prepared to do actual harm to a patient in the name of a legalistic, finicky adherence to abstract principle.

I concur with the assessment that autonomy can be taken to extremes, and that medical ethics requires a more careful balancing of competing principles. But I also object very strongly to a "pendulum" model of the progress of medical-ethical thinking. By this model we were previously too far over on the paternalism side of the pendulum; now we may have swung too far over to the autonomy side; and the solution is to get the pendulum back toward midpoint. That suggests that we got it wrong in some fundamental way when we decided to incorporate respect for autonomy as a basic ethical principle in medicine. I think we got it right, and all further discussion has to be based on a commitment to respect the patient's autonomy. The job is not to "swing back toward" paternalism; it is rather to discern which elements of the old paternalistic ethic served the interests of the patient, and to ask now whether we can preserve those elements within a respect-for-autonomy framework.

We also need to sort out two different ethical questions: what to do in a particular situation, and what it means to be a virtuous person or a virtuous physician. The case study forces us to confront both. It shows us a concrete situation which demands action. But the nature of the situation is such as to preclude any extended, thoughtful weighing of alternatives. A physician's reaction, in the case described, is going to be an outgrowth of the character traits or habits that the physician has been cultivating throughout a professional lifetime.

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The "discussion-stopper" seems to assume that the correct thing to say is obvious. And indeed in this particular case it is probably better, all things considered, to say "of course you'll make it," than to offer disclaimers, statis-

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Center Director: H. Brody, M.D., Ph.D.

tics, or whatever. But we also have to ask what character traits physicians would have to cultivate over time in order to have that response spring automatically and readily to their lips. I cannot imagine this occurring unless shading the truth and withholding vital information had been the habitual practice of the physician in question. And I would submit that such a physician would not be a virtuous physician. In order to be prepared to do the correct thing in this highly unusual case, the physician must have been inclined to do the wrong thing in hundreds of other cases.

The conclusion is stronger when stated in the opposite way. A physician who hesitates for a moment before telling this patient, "of course you'll make it," is a physician who has trained herself to try to tell the truth while at the same time supporting the patient's emotional needs. The fact of her hesitation should not be used against her, even if it's inconvenient in this particular case.

So what should the physician say? I propose the following as part of the ongoing discussion, and not because I have any confidence that I would be clever enough to think of it on the spot were I to be in a situation like this one. (But sometimes the right thing to say does pop into our minds when we have thought about our options carefully beforehand.)

"I know it seems scary, but don't lose hope."

What does this phrase accomplish? First, it should be more effective as reassurance because it recognizes and labels the patient's underlying emotion, fear. Second, it states forthrightly what the patient seems actually to be asking of the physician -- that he be given extra hope in what may appear a hopeless situation. Third, it's literally truthful. Fourth, it recognizes exactly the point that the "discussion-stopper" wants to make -- in the physician's medical judgment, the patient's hope can have a measurable and practical effect on the outcome of the surgery; so not losing hope is "medically indicated" and not just "compassionate."

I am sure that others can think of truthful phrases which are equally good or better. My point is that a little thought will usually reveal that the goals of respecting the patient's autonomy and rallying to the patient's emotional support in a crisis can be achieved in tandem. Our medical instincts and habits should be to try to find the apt blending of the two in each situation, and not to fall back upon either a comforting lie or upon a bald statement of truthful, but unhelpful data.

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Howard Brody is a family physician and Director of the Center for Ethics and the Humanities.

Commentary Two: Judith Andre, Ph.D.

Ordinarily one should tell the truth. But not always, and not always the full and unvarnished truth. This case calls for something in between candor and falsehood.

Many of the standard reasons for telling the truth do not hold here. One of the strongest reasons to tell the truth is to respect the other person's autonomy: the ability, the right, and the responsibility to govern one's own life. Since the patient has no time to do anything -- e.g., to settle his affairs, or make peace with his children -- a lie does not deprive him of those opportunities. Nor does the lie threaten the relationship of trust between doctor and patient. The patient will probably die, and if he lives the lie will either seem to have been the truth, or be accepted as well intentioned. Most significantly, since our state of mind affects outcome, the doctor's reassurance strengthens the patient's slight chance of survival.

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This is quite a different case from the patient first diagnosed with a terminal disease, who has every right to know the full truth. Nevertheless I would argue that the cheerful lie is also out of order.

First, its good effects are not as certain as one might think. Apparently, for instance, the dying ordinarily know that they are dying, whether or not anyone has told them. Granted, this is a trauma patient, not one who has suffered for weeks or months. Yet he, like the rest of us, is probably adept at picking up the subtle nonverbal signs that say, "I am not telling the truth." This patient is likely to know more than the doctor tells him.

True, professional liars can be very accomplished. Health care professionals, however, should not be professional liars. Deception should not come easily to any doctor or nurse. A habit of veracity, of telling the truth even when it is hard to do so, will make it hard to deliver a flat-out lie convincingly. Its therapeutic effects, therefore, might depend upon a habit which few these days would endorse, the habit of lying to patients.

This is to me the most important point. What one does in this situation, without time to consider ahead of time, springs from attitudes of respect or of condescension. The ingrained, lived-out belief that patients have a right to the truth, and that lies are serious disruptions of a trusting and respectful relationship, simply does not allow a spontaneous and convincing lie.

On the other hand, it does not call for what Norman Cousins calls truth-dumping. "Doc, am I going to make it?" from a patient being rushed to surgery does not deserve "Probably not. Sorry about that." There are intermediate responses, neither cruel nor untruthful: "You're going to get the best care possible and I'm going to be with you all the way," for instance; or "Not if I can help it," said in a cheerful voice. I could even endorse "You'd <u>better</u> make it -- [your wife] is going to be waiting for you," said in a tone of voice that suggests one believes the patient will survive. That's misleading; but it

provides those who hear, and the patient, should he survive, the assurance that this doctor takes words and their literal meaning seriously. This is one crucial foundation for the way the doctor relates not just to this patient to all of them, and to his colleagues, his family, and himself as well. A habit of telling the truth, like a habit of lying, is a serious thing.

Judith Andre is a faculty member of the Center for Ethics and Humanities in the Life Sciences.

Commentary Three: Tom Tomlinson, Ph.D.

What should the physician say to his or her patient in this situation? I see fundamentally three options. She can respond directly to his question with a lie. She can respond directly, with the truth. Or she can choose to respond to the patient's need rather than his question.

Of these three, I favor the last, which I will discuss in some more detail in a moment. But first, I must explain why I favor neither truth nor lie.

A truthful response to the patient's question presumes that the doctor owes the patient a true report of his or her belief about the patient's chances. But what could be the ethical basis for this duty? The patient's right to medical information is usually based in a more fundamental right of autonomous choice. Thus, a patient with cancer has a right to be informed of that diagnosis in order to be able to make further choices about treatment, personal and family plans, and the like, in order to better advance the individual's values and goals. In the present case, what autonomous choice could this information serve? A decision whether to proceed with treatment? But this is a patient presenting in an emergency, going into shock, in circumstances requiring quick action if any chance for saving his life is going to be preserved. These are not circumstances that permit effective communication of information (especially very important information about the reliability of the physician's own estimate of the patient's chances), or evaluation of the patient's level of understanding and capacity for deliberation.

If not a treatment decision, what else is at stake for the patient's autonomy? Perhaps if the patient were told the grim truth, he would want to use his remaining time to pray, or reflect on the meaning of his life. Thus, his autonomy is served. But, perhaps more likely, when told the grim truth he is thrown into terrified despair. The placebo effect being what it is, his chances of survival drop even further. Since survival is what he most wanted (hence, his despair), his autonomy is not served by the physician telling the

A right of autonomy, therefore, offers no unambiguous support for telling the truth, except in those unusual circumstances where we have special evidence regarding the patient's goals and values.

(Tomlinson continued on page 6)

truth, since doing so has further obstructed the patient's pursuit of his fundamental goal. A right of autonomy, therefore, offers no unambiguous support for telling the truth, except in those unusual circumstances where we have special evidence regarding the patient's goals and values.

Then why not lie? Well, why not indeed? Respect for autonomy offers no more objection to lying than it provides support for truth-telling. Instead, the objection to lying is that it's gratuitous.

The most fundamental mistake in answering the patient's question directly, with either the truth or a lie, is that it assumes that the patient has asked what it is he really wants to know. Why should that be assumed? We often ask questions that aren't what they literally appear to be. "Does this tie look OK?" is most often not a request for a ruthless critique of my taste, but only the reassurance that I've not dressed myself like a rube from "The Farside." So too, when the patient asks, "Doc, am I going to make it?," why should we assume that the question expresses his felt need to have the brutal truth? The likelihood is that his most ardent desire is to survive, a purpose that the truth will subvert. What's more, he is already aware that the odds may be against him -- why else would the question occur to him -- idle curiosity? His question does not express his need to know, but his need for an ally, someone who will stand beside him against the otherwise terrifying odds.

When that is the motivation for the question, then a literal answer is beside the point, or worse. What the patient really wants is the refuge of solidarity. He wants the doctor to say, "We're sure going to try!"

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Tom Tomlinson is Assistant Director of the Center for Ethics and the Humanities in the Life Sciences and Director of the Interdisciplinary Programs in Health and Humanities.

A Surgeon's Perspective: Keith N. Apelgren, M.D.

For a surgeon's perspective the Medical Humanities Report asked Dr. Keith Apelgren for his response. While Dr. Apelgren appreciates Dr. Spiro's position he does not agree with either the conclusion that the physician ought to lie to the patient in this case or the claim that we have gone overboard with the issue of autonomy. The following excerpt is taken from his response.

> *The question of how his [the patient's] primary care physician should respond to his question, "Am I going to make it?" is an intriguing one. The position that a therapeutic lie should be told in order to enhance chances of survival is a compelling one. However, from a surgeon's perspective this should not be done because it places the surgeon in a*

difficult position, should the patient be in some difficulty intra-operatively. I have asked two or three of my colleagues for their response and we all uniformly would tell the patient "You are very seriously ill. We will try our best to pull you though."

Keith N. Apelgren is Professor of Surgery at Michigan State University.

Announcements

Dr. Martin Benjamin, Professor of Philosophy and an Associate of The Center for Ethics in the Humanities and Life Sciences received the Distinguished Faculty Award at Michigan State University in February. Dr. Benjamin is a pioneer in teaching medical ethics MSU, offering the first course within the Philosophy Department in 1975 and then writing the original NEH grant which provided funding for ethics courses taught in the Medical Humanities program in 1978. With this funding he helped develop and teach courses in ethics in nursing, medical ethics, ethics and animals, and aging and human values. He has served on the staff of the Center from 1978-81, and 1984-85. His recent research and writing have addressed issues of organ transplantation, euthanasia and assisted suicide, pragmatism and medical ethics, and consensus in ethics.

Judith Andre presented "The Week of November 7: Bioethics as a Practice" at the William Bennett Bean Symposium on Philosophy and Medicine, held in Galveston, Texas February 16.

Judith Andre presented "Against `Preventive Medicine'" at the Association for Practical and Professional Ethics held in Crystal City, Virginia, March 2-5. At the same conference professor Andre organized and chaired a panel discussion of ethics in academia called "Devouring Our Young."

Leonard Fleck, Ph.D. will present "Ethical Issues and the New Reproductive Technologies" at the Michigan State Medical Society Conference, "Maternal and Peri-Natal Health" at the Kellogg Center, March 16.

Leonard Fleck, Ph.D. will present a paper, "Rational Democratic Deliberation: Meeting the Challenges of Justice and Rationing" at the Pacific Division Meeting of the American Philosophical Association for the Committee on Medicine and Philosophy, San Francisco, March 30 through April 1, 1995.

"Futility and Hospital Policy" by Tom Tomlinson and Diane Czlonka will be appearing in the March-April issue of the Hastings Center Report.

Medical Ethics and History of Health Care in London will be held June 19 - July 27 at St. Bartholomew's Medical College, London, England. The course, led by Tom Tomlinson and Brian Brown, will address historical and ethical topics regarding health care in the US and the UK. It can be taken for 7 credit hours (4 credits PHL 491; 3 credits HST 487). A fee of $2086 covers housing, program, activities, and admission fees, but does not include tuition, transportation, food, and personal expenses. For application contact Overseas Study at (517) 353-8920. For additional information contact Tom Tomlinson at (517) 432-2691 or by e-mail at 19910tom@msu.edu. Application deadline is March 31, 1995.

Coming Events

The Center for Ethics and Humanities is an academic unit whose faculty teach, write, and consult about bioethics and the other medical humanities. Staff members frequently conduct public discussions about a variety of such topics and we encourage our readers to attend and participate in these forums.

Friday and Saturday, April 21-22: Medical Ethics Resource Network of Michigan Annual Meeting. The conference theme is Ethics in the Continuum of Care. Keynote speaker James Nelson, Ph.D. of the Hastings Center will give a presentation entitled, "'Judgement Difficult': On Clinical and Moral Judgement." The Marriott Inn, East Lansing, MI. For brochure call Jan Holmes at The Center for Ethics and Humanities in the Life Sciences (517) 355-7550.

Thursday through Saturday, June 22-24: Medical Ethics for the '90's: An Intensive Skill Building Workshop. Fifth Annual Summer Ethics Conference. The keynote speaker will be Professor Thomas Murray, Center for Biomedical Ethics, Case Western Reserve University. This workshop is designed for individuals who serve or expect to be serving as members of institutional ethics committees. Kellogg Center, East Lansing, MI. For conference details contact the Office of Continuing Medical Education, A-118 East Fee Hall, College of Medicine, East Lansing, MI 48824-1316, (517) 353-4876.

Sunday, June 25: Advanced Summer Bioethics Workshop: Ethical Issues in Managed Care. Workshop faculty are Howard Brody, M.D., Ph.D., Leonard Weber, Ph.D., Leonard Fleck, Ph.D., Judith Andre, Ph.D., and Susan Goold, M.D., MSA. Kellogg Center, East Lansing, MI. For conference details contact the Office of Continuing Medical Education, A-118 East Fee Hall, College of Medicine, East Lansing, MI 48824-1316, (517) 353-4876.

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