How the doctor's nose has shortened over time; a historical overview of the truth-telling debate in the doctor–patient relationship

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INTRODUCTION

In medicine, the legitimacy of deception has been the subject of debate for centuries. Fletcher called the issue of truth-telling an 'old and perennial problem, giving cause in every age to complaints against doctors as masters of equivocation.'[1] Despite the categorical rejection of deception in several codes of ethics, the moral acceptability of deception is still a contentious issue in contemporary medicine.[2–4] In many parts of the world, it is common for doctors to withhold a diagnosis of cancer from their patients.[5–8] In this article, I shall not debate the ethics of truth-telling and deception, but will rather present some historical antecedents to the debate and provide reasons behind the transition, in the Western context, from a deception-friendly professional disposition to an overtly deception-phobic one. However, many of the ethical arguments for and against benignly intended deception are as germane today as they were at the time.

METHODS

This article is not intended to be a thorough historical analysis but an overview of the views and reasoning of important medical figures on the issue of truth-telling and deception. My starting point was Jennifer Jackson's '*Truth, Trust, and Medicine*' which contains a brief history of truth-telling practices in Western medicine.[14] I flesh out her account by examining additional primary and secondary sources and encompass the views of a wider range of historical figures. In the second part of the article, I adopt a broader perspective to shed light on the variability of truth-telling practices across cultures.

LIES AS MEDICINE: TRUTH-TELLING AND DECEPTION IN ANCIENT GREECE

The Hippocratic corpus, believed to have been written by several authors in the fourth and fifth centuries BC, is silent on the issue of lying to patients, but warns doctors of patients' lies: 'Keep a watch also on the faults of the patients, which often make them lie about the taking of things prescribed.'[9,10] The Hippocratic writings, however, encouraged doctors to be economical with the truth and to 'reveal [. . .] nothing of the patient's future or present condition.' Such honest revelations, the Greek author of the *Decorum* continues, have caused many patients to take 'a turn for the worse.'[10]

Writing at around the same time, Plato assessed the legitimacy of doctors' lies based on their likely effects on the patient's health. For Plato, a doctor's primary duty was to improve the health of his patient, hence trickery was acceptable if employed to that end. In *The Republic*, Plato writes:

> 'But what of the falsehood in words—when and for whom is it serviceable so as not to merit abhorrence? Will it not be against enemies? And when any of those whom we call friends owing to madness or to folly attempts to do some wrong, does it not then become useful to avert the evil—as a medicine?'[11]

Plato draws an analogy between lies and medicines, as both may be used to help others overcome evil. Just as a drug may prevent the formation of pernicious tumours, so may a lie prevent the occurrence of undesirable views, beliefs or actions.

EARLY SYMPTOMS OF DISAPPROVAL: THE 18TH AND 19TH CENTURIES

Writing in the 18th century, John Gregory (1724–1773) and Thomas Percival (1740–1803), both doctors themselves, continued the defence of doctors' benevolent lies to patients. They considered deception to be morally justified when used in the patient's best interests. So influential and respected were Percival's views that the American Medical Association (AMA) incorporated many of them verbatim in its first Code of Ethics in 1847. The original code instructs doctors to avoid making 'gloomy prognostications' to the patient but recommends informing friends and relatives of the situation. Only if 'absolutely necessary' may the doctor share the prognosis with the patient. The words of Percival

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were used to support and explain the recommendation against disclosure:

> 'The life of a sick person can be shortened not only by the acts, but also by the words or manner of a physician. It is, therefore, a sacred duty to avoid all things which have a tendency to discourage the patient and to depress his spirits.'[12]

According to the AMA's code, disclosing a 'gloomy prognostication' was quite simply bad medicine in all but a few exceptional cases. Percival's argument rests on the idea, still popular today, that the emotional state of the patient directly affects his ability to fight off disease.

Reverend Thomas Gisborne (1758–1846), a contemporary of Percival, offered an opposing view. He anchored his distaste for the practice on grounds of conscience and on the observation that lies usually fail to convince patients anyway.[13] Instilling hope should be encouraged only 'as far as truth and sincerity will admit.'[13] Furthermore, Gisborne argued, there are practical problems with lying: patients who are acutely ill instinctively *know* that they are near the end and see straight through the benevolent lies of doctors affirming the contrary.[14]

THE GROWING SUPREMACY OF TRUTH: THE 20TH CENTURY AND BEYOND

For W John Thomas, the post-Medieval history of doctor-patient conversations 'might be characterized as a triumph of hope over truth.'[13] The 20th century, on the other hand, heralded the gradual decline of hope and the growing supremacy of truth. In the early part of the twentieth century, Richard Cabot (1868–1939), based on his own experience as a doctor in Boston, questioned the relationship between truth and loss of hope, and stressed the ability of many patients to cope with bad news. Cabot believed that the gains of a lie were only temporary and, ultimately, outweighed by the long-term benefits of the truth: 'a lie saves a present pain at the expense of a future greater pain.'[14–16]

William Osler (1849–1919), probably the best known doctor in the Western world at the turn of the century, appeared to favour both truth-telling and deception, depending on the context. He seemed to favour truth-telling in some situations although he emphasised the importance of maintaining hope in the patient. In 1909, on the subject of tuberculosis, Osler commented:

> 'It is a hard matter and really not often necessary (since nature usually does it quietly and in good time) to tell a patient that he is past all hope. As Sir Thomas Browne says: ''It is the hardest stone you can throw at a man to tell him that he is at the end of his tether;'' [. . .] and yet, put in the right way to an intelligent man it is not always cruel.'[17]

This last statement suggests that Osler *did* sometimes conceal grim news to maintain a patient's hope, especially if he deemed the patient unable to cope with the information. Michael Bliss, in his biography of William Osler, supports this by pointing out Osler's tendency to 'cushion a grim outlook' and his strong emphasis on maintaining hope.[18] Nevertheless, the passage also reveals that Osler believed in the possibility of disclosing gloomy news to patients while maintaining hope.

Like Osler and Percival, the distinguished Professor of Medicine Lord Cohen stressed the vital importance of hope. In an essay on the doctor-patient relationship, he wrote:

> 'No one who has spent a lifetime in practice can have failed to observe the immediate effect on the patient of telling him that he is the victim of a fatal and it may be a painful disease such as cancer.'[19]

Although in favour of withholding the truth from certain patients, he disapproved of doctors' lies to direct questions from patients, thereby drawing a moral distinction between withholding information and lying. He did not, however, explain the rationale for this distinction. In the same volume, Maurice Davidson argued that doctors should disclose information even to severely ill patients, or patients with a poor prognosis. Davidson based his argument on the belief that 'a patient has a perfect right to demand reliable information about his condition, and that the fulfilment of vitally important duties may be contingent upon his reception and assimilation of such information.'[20] Davidson's admission that his views on the matter are 'unusual' and may be subject to 'bitter criticism from many of my professional brethren' suggests that his position was not widely held in the 1950s.[20]

In an age where the most important effect of many drugs and medicines was probably the placebo effect—and this age extends to the first few decades of the 20th century—a doctor's reputation was crucial to the success of his practice and was based partly on the ability to instil a sense of confidence in his patients.[21] Kenneth Lane, in his autobiographical account of life as a GP in the 1930s, recounts prescribing the 'latest bit of fashionable nonsense.'[22] For psychosomatic conditions, these drugs often appeared to be effective, no doubt due to the high esteem in which patients held their doctors. Doctors thus considered instilling a strong belief in the efficacy of the drug to be of prime importance. A few lies or half-truths may well have achieved this. Shorter quotes the pharmacologist Harry Gold, who said 'Honest doctors are not likely to find it easy

to give evidence of enthusiasm for coated sugar-pills.'[21] In this context of therapeutic paucity, hope-instilling deception may have been an important weapon in a doctor's remedial arsenal.

This changed in the 1950s when effective drugs became widely available and doctors, perhaps as a consequence of the drugs' effectiveness, devoted less time to showing concern or comforting the patient with protracted conversations. The dispensation of drugs was in itself sufficient to relieve the patient's anxieties.[23]

This brief historical overview reveals clear differences in the attitudes and practices of doctors regarding truth-telling and deception. There is little doubt that, even within a given time span, doctors varied in their views on the acceptability of deception, just as they do today. Nevertheless, it would be reasonable to assume that lies and deception were more common in the past—and indeed more accepted by the medical profession as a whole—than they are at present. The change towards greater openness seems to have occurred in a short space of time, during the second half of the last century. We can trace this shift in practice by examining empirical studies on doctors' disclosure of cancer diagnosis and prognosis to patients.

TRUTH-TELLING ABOUT CANCER: FROM EXCEPTION TO NORM

In 1953, Fitts and Ravdin mailed questionnaires to 444 doctors in the Philadelphia area of the USA.[24] Sixty nine per cent of the respondents indicated that they never or usually did not inform the patient of a diagnosis of cancer, 28% that they usually informed the patient and 3% that they always informed the patient. The most frequently given reason for not telling the patient when the doctor's usual practice was to disclose the diagnosis was 'unfavorable emotional reaction'.

The second most cited reason in the survey was the patient's family request not to inform, reflecting a time when relatives often knew a diagnosis or prognosis before the patient. When the usual practice was to withhold the diagnosis, the primary reasons given for exceptionally telling the truth were the patient's refusal of treatment and the patient's special need to plan the future.[24] A comment by one of the respondents reminds us of the strong and, at the time, prevalent association between cancer and death:

> 'I feel strongly against letting the patient know he has cancer! To all people, intelligent or not, the word cancer means a death sentence, and, even if you meet an occasional patient who insists on knowing the worst and says that it will not affect him one way or another, he will be mentally affected by knowing the worst.'[24]

The prevailing construal of cancer as a 'death sentence' was undoubtedly an important factor in doctors' reluctance to disclose the diagnosis. What is surprising is that this strong tendency to withhold a diagnosis of cancer was reported only three years after the publication of a study revealing that 89 out of 100 cancer patients wished to know their diagnosis.[25]

When considering these seemingly accepted deceptive practices, it is worth remembering the radically different nature of the doctor–patient relationship in the first half of the 20th century. Shorter notes that the typical patient 'was willing to tolerate, indeed expected, a kind of medical tyranny that today would produce shocked exposés in the press.'[21]

Non-disclosure of a cancer diagnosis appears to have been the norm throughout the 1960s. In 1961, Oken conducted a study in Chicago which showed that 90% of the 219 doctors sampled said that they would not usually inform a patient of a cancer diagnosis.[26] Not only did most of the doctors prefer to conceal the information, but many said that they actively changed the diagnosis to avoid any mention of cancer. Oken observed that nearly all the doctors reported having lied in this way several times in the past, typically when the patient was at the terminal stages of cancer.[26]

Around the same period, Glaser and Strauss declared that 69% to 90% of doctors in their sample preferred not to tell patients about a terminal illness.[27] The result of this propensity to withhold the truth from dying patients occasionally gave rise to what the authors termed the 'ritual drama of mutual pretense', where both patients and medical staff—well aware that death was near—pretended to each other that all was well.[27] The medical staff, especially nurses, had various tactics and countertactics to conceal the truth. Nurses would talk of the patient's future plans, avoid discussing the future altogether, or claim ignorance regarding the patient's health. Similarly, suspecting patients had myriad ways, ranging from direct questioning to the observation of the nurses' behaviour, to uncover the desired information.

By the late 1970s, this phenomenon had become much rarer. In 1979, Novack *et al*. submitted an almost identical questionnaire to that used by Oken in 1961 to American doctors and found that 97% said that they *would* disclose a diagnosis of cancer.[28] The respondents saw age, intelligence, relative's wish about informing the patient, and emotional stability as the four most important factors in deciding whether or not to tell the patient.

Yet, despite the apparent reversal in dominant attitudes, Novack *et al.* only obtained a 40% response rate to their questionnaire. It is probable that those who *did* bother to complete and return the questionnaire were those physicians who felt most strongly about the issue one way or the other. A second caveat relates to the discrepancy

between what is affirmed in a survey and what goes on in practice. In an interview-based study, Miyaji revealed how doctors can allude to the crucial importance of truth-telling in the course of an interview, giving all the textbook arguments to support it, while abiding by quite different rules when disclosing information to patients.[29]

When the association between cancer and death abated, partly as a result of better diagnostic procedures, more effective treatment, and greater public understanding of cancer, it became possible to reveal the disease without revealing the prognosis. The change in the practice of disclosure may therefore be, at least in part, the result of medical and socio-cultural changes, rather than a shift in physician ideology regarding truth-telling in medicine. The reluctance of doctors to disclose an adverse prognosis in the late 1970s may be based on the same reasons that doctors invoked to justify non-disclosure of cancer diagnosis twenty years (and, indeed, twenty centuries) earlier.

The shift in cancer disclosure was, and still is, far from universal. Around the time of Novack's study, in the late 1970s, the Italian Deontology Code of the Italian Medical Association stated that 'A serious or lethal prognosis can be hidden from the patient, but not from the family.'[30] Today, in many countries, including Lebanon, Singapore, China and Japan, patients with cancer are often not told their diagnosis, let alone their prognosis.[7,31–33]

Even in the USA, Miyaji and Christakis have shown that doctors usually emphasize treatment and downplay prognosis.[29,34] In a study involving 365 American doctors predicting survival in 504 cancer patients, Christakis found that doctors usually do not communicate their 'best and most objective' prognostic estimates to their patients.[34] When asked about the predictions they would make to patients referred for hospice care, the doctors said they would disclose their actual beliefs on the prognosis only 34% of the time. By their own accounts, the doctors would withhold prognostic information from 25% of patients.[34] The rest of the time, they would give a deliberately optimistic estimate or, less often, a pessimistic estimate.[34]

In the UK, disclosing a grim prognosis is also a variable practice. In a 1997 study on the attitudes of surgeons towards the psychological aspects of surgery, Burton and Parker found that only 37% of the surgeons interviewed had a policy of *always* telling a patient about the presence of malignancy.[35] These studies indicate that the dictums of the GMC and AMA, which embrace truth-telling and reject deception, are not always followed in practice.[3] Whether they ought invariably to be so is another question.[4]

CONCLUSION

A historical and cultural examination of truth-telling practices reveals that the arguments for and against benignly intended deception vary little across time, and suggests that the perceived acceptability of deception is dependent on the state of the doctor-patient relationship, which is itself situated in an ever-changing social context. In Western cultures, the paternalism prevalent throughout most of medicine's history has been replaced in the last forty years with a strong tendency to allow patients to exercise their autonomy. Patients have the right to make their own choices regarding their health care, to refuse even life-saving treatment, and to obtain detailed information about treatment options.

The relationship between doctors and patients has shifted from one of unquestioning acquiescence to a more levelled 'partnership'. This shift has empowered patients by giving them an authoritative voice in medical decision-making. The permissibility of doctors' deception, as part of a generally disfavoured paternalism, has also been affected by the advent of this new mentality and, to the delight of some and the chagrin of others, a more complete and truthful disclosure has emerged.

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