Truth-Telling and Deception in Contemporary Medical Practice – an Empirical and Philosophical Analysis

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Abstract

The project aims to clarify the ethics of benignly intended deception in medical practice by bridging empirical and philosophical medical ethics. Using a combination of three methodologies (1. an argument-based, philosophical methodology, 2. a qualitative, social science-based, multi-methods approach informed by Grounded Theory, and 3. reflection on the interplay between the first two methods), the project investigates the views of doctors, patients, and members of the general public on truth-telling and deception, examines the moral reasoning underlying these views and compares them with the philosophical and bioethical literature. Finally, I suggest some practical ways to reconcile differences between the groups that might improve current practice.

Following a detailed analysis of the concepts of lying and deception, I explore the ethics of deception first in everyday life, then in the medical context. I argue that doctors' benignly intended deception can sometimes be morally justified from a philosophical perspective and show empirically that in my sample populations this non-absolutist position is widespread. Using data gathered from 229 questionnaires concerning a range of hypothetical scenarios, 35 semi-structured interviews and 2 focus groups, the empirical research examines respondents' understanding of the concepts of lying and deception, the moral evaluation of deceptive acts, the functions of deception in the doctor-patient relationship, and respondents' views and reasoning on the idea of sharing information about disclosure preferences using an 'ethics history sheet'.

Methodologically, the thesis highlights the value of combining philosophical research and social science. By identifying issues of theoretical or empirical interest, supporting empirical assumptions in philosophical arguments and seeking workable solutions to bioethical problems, interdisciplinary collaboration between medical ethics and social science can result in a bioethical analysis that is philosophically rigorous and grounded on the realities of clinical practice.

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Responsibility for the errors within is, of course, mine alone.

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CHAPTER 1

Introduction

We have all been, at one time or another, patients. Whether in a hospital or a General Practice surgery, we have talked to doctors about our health, hoping that they would inform us on the nature of our illness and, with a little luck, fix the problem. As patients, we generally expect doctors to volunteer some information relevant to our health and to answer our questions clearly and truthfully. This, however, does not always happen. Occasionally, doctors omit information, deceive or even lie in order to allay our fears or spare us from distress. Sometimes, doctors deceive us with less virtuous motives, such as to avoid the threat of litigation. This thesis will largely ignore the latter instances of deception. From an ethical viewpoint, they are of limited interest.

Recently, studies have been published on doctors deceiving incompetent patients, insurance companies and, more intriguingly perhaps, their own colleagues[1-4]. In this thesis, I limit the scope of my research to doctors benevolently deceiving *competent* patients.

Background to the research

John Lantos wrote of medicine's 'long and distinguished tradition of lying'[5](p.85). From the days of Plato and Socrates through to the present day, via John Gregory and Thomas Percival in the 18th century and William Osler in the 20th, the most esteemed doctors have deceived their patients with good intentions[6 7]. Yet, aside from a few dissenting voices in the 18th century, it is only recently that any prolonged attention has been devoted to the ethics of deception in medicine.

In 1961, the physician Donald Oken commented that 'no problem is more vexing than the decision about what to tell the cancer patient'[8](p.1120). From Oken's study, the verdict on the acceptability of cancer disclosure was overwhelmingly clear: 90% of

the doctors surveyed did not usually disclose a diagnosis of cancer to the patient[8](p.1120).

In the following decades, disclosing a cancer diagnosis became the norm, at least in places such as the United States and the United Kingdom, although the issue of whether benignly intended deception was ever justified remained at the fore. The philosophers Sissela Bok in the 1970s and Jennifer Jackson in the 1990s and 2000s both devoted much attention to this question[9 10]. The change in the nature of the doctor-patient relationship, the entrenchment of the concept of informed consent in everyday medical care, and therapeutic and diagnostic developments altered the perceived acceptability of deception in medicine.

The shift from concealment to disclosure, however, was not so sweeping that it pervaded every aspect of medical practice. There were -- and, indeed, still are -- situations where doctors deceive their patients on grounds of benevolence and assumed beneficence. In the United States, doctors' reluctance to disclose an unfavourable diagnosis, for example, has now given way to a reluctance to disclose a grim prognosis[11](p.185). In the present research, many doctors recount instances of benevolent deception.

In the 1980s, the Code of Ethics of the American Medical Association, hitherto silent on the issue, instructed doctors to 'deal honestly with patients and colleagues'[12]. In the UK, the General Medical Council uses the epithets 'honest' and 'trustworthy' to describe the ethical doctor[13]. But what is inscribed in these noble codes -- the appeal to honesty and openness -- is distinct from what is happening at the coalface. Several published studies and comments have exposed this discrepancy[11 14-16]. As Jackson points out, this incongruity could indicate either that many doctors are acting unethically or, alternatively, that the codes are simplistic[6](p.5).

The mismatch between the minimalist dictums of codes of ethics and the actual practice of doctors is, on reflection, unsurprising. The complexity of medical practice, of which the application of medical knowledge is but a part, cannot be accounted for by phrases as succinct and categorical as 'be honest and trustworthy'. In general,

there is little doubt that doctors should be honest with their patients but there will be cases where the principle of honesty will clash with other moral concerns. What if honesty is likely to endanger the patient's health, or even life? What if telling the truth runs the risk of destroying the patient's remaining hope? This project concerns itself with situations where honesty may not be desirable, where the dictum of the GMC may not provide sound ethical advice. It will attempt to answer the question: 'are doctors ever justified in lying to or deceiving their patients and, if so, why?'.

Research problem

Although the GMC instructs doctors to be 'honest' and 'trustworthy', it is unclear what this means in the context of the doctor-patient relationship?[13]. What and how much information do doctors need to disclose to satisfy the honesty requirement? If being honest requires telling the truth, what determines the content of 'truth'? Does it include an unrequested discussion of prognosis? What is the relationship between truth-telling and deception, and between truth-telling and trust? What exactly constitutes deception and lying? These questions, which I tackle in the following chapters, are closely related to our initial question about the moral acceptability of deception.

Doctors and medical ethicists have hardly turned their attention to the semantics of deception, focusing instead on truth-telling. Simply to ask whether doctors are morally required to tell the truth in certain circumstances is to ignore an important facet of the debate, namely that of the legitimacy of deception. From a normative viewpoint, limiting the remit of the discussion in such a way fails to provide enough action-guiding advice. If, after much analysis, we conclude that doctors need not 'tell the truth' in situation X, does that entail or at least condone the use of deceptive strategies in that same situation? And, if so, does the deceptive method itself make any difference to the ethical assessment of the act? This thesis hopes to fill these lacunae by untangling the concept and ethics of deception through philosophical and empirical analysis.

Some of the arguments in the bioethics literature rest on untested empirical assumptions. Jennifer Jackson, for example, claims that lies lead to a greater loss of

trust than other forms of deception[6]. To test these assumptions and to reflect on the philosophical arguments in the light of empirical investigations, I conducted qualitative fieldwork studies to discover what doctors, patients and members of the public think about issues of truth-telling and deception in medicine and, especially, the reasons underlying their views. This allowed me to establish whether the arguments of the philosophers and medical ethicists were reflected in the reasoning of the various stakeholders and vice versa. Are the kinds of issues and considerations found in the academic literature deemed important by those faced with these problems?

The thesis thus explores, in a practical manner, the value of social science research to a substantive bioethical problem. It attempts to integrate methods from social science and from philosophical medical ethics to achieve an analysis that is philosophically rigorous whilst empirically informed by accounts of a diverse group of 'stakeholders'. The thesis is broadly divided into three parts: a philosophical section examining ethical and philosophical issues relating to truth-telling and deception, a central methodology section explaining the rationale behind combining bioethics and social science, and an empirical section presenting the findings and reflecting on their implications for the bioethical analysis. I decided to place the methodology section in between the philosophical and empirical segments (rather than at the beginning of the thesis) to highlight some similarities between my chosen philosophical and social science methods.

The aim of the thesis was not solely to clarify the ethics of truth-telling and deception but also to try to arrive at some *practical* suggestions that may help doctors make well-informed decisions. Were there any notable differences in views and reasoning amongst the three groups studied and, if so, what were they? Might there be ways to improve current practice by attempting to reconcile, or at least reduce, the different perspectives in a manner mutually acceptable to all groups?

Overview of methodology

Like Holm in his study on the ethical reasoning of doctors, I used a qualitative methodology to guide the empirical work[17]. A qualitative approach fitted the heavy emphasis on understanding the *reasoning* of respondents (rather than simply their

conclusions) better than a quantitative approach, which would have been ill-suited to capture nuances in respondents' justifications. Personal experiences of deception could be extracted in richer detail using qualitative methods that allowed the respondents' narrative to flow. The explorative flexibility of certain qualitative methods, such as interviews and focus groups, and the possibility of asking respondents for explanations and clarifications about interesting or imprecise answers provided strong reasons to opt for a qualitative approach.

The project combined three methodologies:

1. An argument-based, philosophical methodology derived from the philosophical, theological and medical ethics literature

2. An empirical approach informed by Grounded Theory seeking to discover the attitudes and reasoning of relevant 'stakeholders'*, and

3. Reflection on the interplay between the results of the first two methodologies

Put simply, the philosophical methodology allowed me to construct and evaluate arguments. The Grounded Theory-informed approach produced a dense account of the respondents' views and reasoning on truth-telling and deception. Finally, reflecting on the interplay between the findings connected the philosophical and empirical dimensions of the thesis by constantly comparing the 'data' from each component using a form of 'reflective equilibrium'.†

To enrich the empirical research on the issues of truth-telling and deception, I adopted a multi-methods approach by triangulating questionnaires, semi-structured interviews and focus groups. Triangulation -- the combination of several methodologies or methods to investigate a common phenomenon -- thus occurred at two levels: at the level of methodology and the more specific level of method.‡

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* I provide an account of Grounded Theory in chapter 6 (p.166-171).
† Van Delden and van Thiel characterise reflective equilibrium as a 'dialogue [...] going back and forth between information stemming from practice [...] and from theory [...][18](p.254).
‡ A methodology, according to Strauss and Corbin, is a 'way of thinking about and studying social reality', whereas a method is a technique for collecting and analysing data[19](p.3).

Outline of thesis

After this introduction, chapter 2 dwells on definitional issues embedded in the concepts of deception and lying. Past attempts to define these terms are presented -- and challenged -- before I tentatively suggest my preferred definitions and present a way of conceptualising deception.

Chapter 3 examines truth-telling and deception in everyday life, and in particular different positions that moral philosophers and theologians have held on the issue. I begin by examining the arguments of 'absolutists', who argue that lying or deception is *never* morally acceptable, and then focus on some non-absolutist stances espoused within several moral theories, including utilitarianism, rights-based theories, contractualism, virtue ethics, and pluralism.

In chapter 4, I consider truth-telling and deception in the context of medical ethics. I briefly review guidelines and regulatory literature on truth-telling and examine the arguments of doctors and medical ethicists who have written on the subject. Finally, I discuss the meaning of trust and the relationship between trust, truth and truthfulness.

Chapter 5 provides a descriptive account of how doctors deal -- and have dealt -- with truth-telling issues in actual practice. Using a historical approach, I focus on some variations in truth-telling practices in medicine, highlighting the relatively recent changes in doctors' attitudes to disclosure of information in the United States and the United Kingdom.

Chapter 6 begins by examining the interplay between empirical research and philosophical medical ethics, and introduces various methods in philosophical research. I then justify my choice of qualitative methodology and the specific research methods selected. The next section details the practical aspects of the research, such as sampling, recruitment and methods of data analysis. The chapter closes with a section on the methodological limitations of the research.

The next four chapters are devoted to the presentation and analysis of the empirical findings and their implications in the light of the earlier philosophical analysis. Chapter 7 deals with respondents' understanding of the concept of deception; chapter 8 focuses on respondents' moral evaluation of deception, including the perceived moral differences between lying and other types of deception; chapter 9 looks at the various functions of benignly intended deception in the doctor-patient relationship, and chapter 10 examines the idea of sharing disclosure preferences between doctors and patients.

Chapter 11, the final chapter, reviews the findings in relation to the primary aims of the thesis, and broadly discusses the implications of the thesis for the bioethical debate on truth-telling and deception in medicine, for clinical practice, and for bioethics and social science methodology. The chapter ends with a self-critique of the study and suggestions for further research.*

The box below summarizes the key conclusions of the study:

Summary box of main conclusions

1. Despite general condemnation of lying and deception across the spectrum, sound philosophical arguments can justify benignly intended lies and deception in some circumstances, even within moral philosophies apparently absolutely opposed to all lies and deception.

2. The majority of respondents in my empirical research, whether doctors, patients or members of the public, adopt a pluralist, non-absolutist position on the morality of doctors' benignly intended deception.

3. Respondents' understanding of the definition and morality of deception in medicine is often unclear, inconsistent and unstable.

4. In morally contentious cases, avoiding the term 'deception' in medical ethics in favour of less morally loaded descriptions will enable conceptually clearer moral assessments.

5. An 'ethics history sheet', eliciting patients' informational preferences, may reduce misunderstandings between doctors and patients regarding disclosure.

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* Appendices A to J are appended to provide additional information for the interested reader. They are not technically part of the thesis, nor are they essential to it.
A sequential list of references referred to in the thesis is provided at p.296-308.

CHAPTER 2

Untangling Deception*

To answer the question on the moral acceptability of deception in medicine, I must first address a more fundamental question: what is deception? Behind the apparent simplicity of the question lies a tangled web of definitions. Sociobiologists, ethologists, anthropologists, child psychologists, linguists and philosophers have differed in their interpretation of deception, each employing the term to describe behaviour specific to their respective fields of study[20]. Despite many studies on deception, both among human and non-human animals, Mitchell acknowledges that 'few researchers offer an explicit account of what is involved in categorizing an act as deception' [20](p.3). Galasiński expresses a similar thought when he claims that 'there is probably only one characteristic of deceptive communication that is widely agreed on in the literature, namely, that an act of deception has to be intended by the deceiver', and even this last point is contentious if we consider outcomes in which people are *un*intentionally deceived [21](p.18).†

This lack of definitional agreement is not limited to academics, but extends also to doctors and laypersons. Miyaji concluded from her study that doctors differ in their definitions of deception and, in particular, of lying[15]. Novack *et al.* arrived at the same conclusion in their study:

> Some [doctors] believe that they never or rarely deceive: one physician wrote, "No good doctor 'deceives'! Perhaps better terms might be: consideration, expression, compassion...support, tailor management to patient's needs." Others believe that they frequently deceive: "Deception...every time we say 'you'll feel a pinch' for a lidocaine injection or 'this won't hurt' for a bone marrow"[22](p.2983-2984).

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* A shorter version of this chapter will appear in a forthcoming issue of the *Cambridge Quarterly of Health Care Ethics* (Fall 2006).

† A brief discussion of the distinction between intentional and unintentional deception is provided in appendix A (p.309).

The notion of 'deception' is thus semantically complex and subject to interpersonal variation. The sociologist John Barnes, by focusing specifically on lying, avoids stepping into what he calls the 'labyrinths of deception'[23](p.10). I do not have this luxury. I must venture into the Daedelian labyrinths, although in this chapter I will not hazard too far in for fear of losing the thread of the matter at hand.*

What is deception?

Deception can be broadly divided into intentional and unintentional deception. In this thesis, I am concerned with the former type of deception, deception that occurs through a conscious intention to mislead. Unless otherwise indicated, I shall try to restrict all references to deception to *intentional* deception.

The truth value (i.e., the truth or falsity) of an assertion is, in itself, inadequate to determine whether or not an act is deception. A person can utter a sequence of true statements whose irrelevance or obscurity is such that they deceive as convincingly as a lie. Truthfulness clearly requires more than the mere avoidance of lying, and an utterance can deceive although it is neither true nor false. Galasiński gives the famous "Have you stopped beating your wife?" example as a sentence that has no truth value but which may still be deceptive[21](p.19).

In what Bilmes calls the 'world of total meaning', where every utterance or pause can be meaningful, silence itself can be deceptive[24]. If someone asks, in an accusatory tone, "well, did you?" and the accused remains silent, intending to imply "yes" (when the accusation is false), the silence is used to deceive. The linguist Saville-Troike considers silence to be a communicative act which, like spoken discourse, can be employed to influence the 'listener'[25](p.6-7). Within a comprehensive theory of communication, silence should be recognised as a content-full unit of communication, albeit one heavily dependent on context. She writes 'silence [...] can have similar truth value to speech, and thus can intentionally be used to deceive and to mislead'[25](p.7).

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* However, I briefly attempt to illuminate several pathways of deception in appendices A and B.

Deception, then, can be non-verbal. A smile (to feign liking someone) or a nod (although you strongly disagree with the speaker) can constitute deception. As mentioned earlier, the failure to disclose an important piece of information may also be deception. One major difficulty in pinpointing deception by omission relates to the synoptic nature of human communication[26]. If I ask John about the film he saw last night, I do not expect a detailed scene-by-scene account but only a rough sketch of the story and, at most, a brief evaluation of the film. In other words, people select the information they give to others based on the time available, the expectations of the speakers, the limitations of their own memories, and so on.

False belief

Much of the literature on deception incorporates the notion of 'false belief' into the definition of deception[27]. In so doing, the authors avoid the pitfalls of relying on the truth value of utterances. The definitions revolve around a version of the following:

Deception (a): Deception is a communicative act intended to induce or maintain what the agent believes to be a false belief in the target.

Galasiński, however, identifies a problem with this definition: a renowned liar may deliberately induce a *true* belief in the hearer by saying something false[21]. So, although the agent is not trying to create a false belief in the target, he may be deceiving him:*

> [...] the target of the deceptive act is manipulated into thinking what suits the deceiver; that this happens to be the truth is, in my opinion, of minor importance.[21](p.20)

A concrete example will clarify this: imagine I witness a gun-toting criminal pursuing someone I deeply dislike. The criminal, who distrusts me greatly, asks me for the whereabouts of my nemesis. Intent on seeing my fleeing foe injured by the thug and expecting that the latter will do the opposite of what I tell him, I point to the opposite direction and support this verbally. In short, my intention is to make him believe something that is *true*, although the statement itself is false. This would

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* For no other reasons than grammatical convenience and stylistic fluency, I have used the masculine form for pronouns throughout the thesis.

constitute a case of deception although I am not inducing a false belief. The 'false belief' definition therefore fails to cover all types of deception. But is this so?

The 'traditional' definition (**Deception (a)** above) can still work if we say that I have deceived the criminal not about the whereabouts of the fugitive but about my own truthfulness. In other words, the criminal (C) believes the proposition Φ (= Sokol will lie). I know that C believes Φ (= Sokol will lie), therefore I decide to ¬ Φ (Sokol will not lie), thus inducing a false belief in C who erroneously thinks Φ.

Galasiński adopts another approach to overcome the problem: he alters the definition of deception by introducing the notion of manipulation[21]. His new definition, which has eradicated the phrase 'false belief', is stated as follows:

> **Deception (b):** deception [is] a communicative act that is intended to induce in the addressee a particular belief, by manipulating the truth or falsity of information '[21](p.20).

Under this definition, a liar who deliberately says something false to make someone believe the truth is still deceiving the 'target' by manipulating factual information to attain a hidden goal.

The main problem with this definition is the inclusion of the equally unclear concept of manipulation, which itself needs to be elucidated. What does 'manipulating' mean? In what way is it distinct from straightforward assertion?* Besides, one can deceive by manipulating not the truth or falsity of information but by varying its quantity or relevance (e.g., by providing insufficient or excessive, though true, information, or true but irrelevant information). Sarcasm and irony also seem to fit Galasiński's definition, but it would be odd to consider them deception.

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* Galasiński does provide a definition of manipulation: 'an attempt to affect the target in such a way that her or his behavior/action is an instrument of attaining the goals of the manipulator, who acts without using force but in such a way that the target does not know the goal of the manipulator's action.'[21](p.21). I am not convinced that this definition captures what people typically understand by the notion of 'manipulation'. We often do not know the goals of people's actions or utterances, but this does not necessarily mean we are manipulated. Like deception, manipulation is a complex notion, heavily dependent on context.

Like Galasiński, Ekman avoids using the phrase 'false belief', and focuses instead on the intention to *mislead*[28]. Merging lying with other deceptive strategies, Ekman defines a lie as follows:

Deception/lying (c): deception/lying is a deliberate attempt to mislead a 'target', without prior notification of this purpose and without having been explicitly asked to do so by the target.

His broad definition of a lie encompasses concealment. A doctor who deliberately conceals information about his terminally ill patient is, according to Ekman, lying although no false information has been uttered. The concealment constitutes lying because it is a) intentional b) misleading and c) has not been requested by the patient. Whilst acknowledging that liars generally prefer concealment to falsification, Ekman suggests that both types are equally reprehensible. The targets may be harmed to the same extent in both cases. Concealers who believe that their lies are morally less bad than those of falsifiers are indulging in self-deception. They can persuade themselves that the addressee either already knows the truth or does not want to know it. They can also believe that they are not, by their definition, *lying* to the addressee. These are plausible explanations of why some deceivers prefer concealment over falsification, but are there other reasons for this preference? Will the respondents of the present study reflect the preference for concealment over falsification?

Ekman's attempt to view concealment as a form of lying is, in my view, flawed, at least because of its implausibility; his definition may suggest that most of us are frequently lying. If I notice that the person standing next to me has his zip undone, and I don't say anything, am I lying? Certainly I am not in the commonly used sense of the word. I am intentionally withholding the information and have not been asked to do so by my unzipped neighbour. The question then is: am I misleading him by withholding the information? This raises the definitional problem of what it means to mislead a person, which again is similar to my initial question 'what is deception?' The inclusion of 'mislead' in a definition of deception amounts to a tautology. For this reason, I am not convinced that Ekman's definition clarifies our understanding of deception. Replacing a problematic term with an equally problematic one does not resolve the definitional conundrum.

I am also sceptical of Ekman's 'request condition' which states that a lie can only be a lie if it has not been requested by the addressee. Consider the following scenario: an old man asks his GP not to inform him of any fatal diagnosis and allows him to lie if necessary. A year later, the old man asks "I don't have cancer, do I?" and the GP, remembering the prior request, replies: "No, you don't". The GP has done as requested, but it seems clear that he has nonetheless lied (assuming he knew the patient had a fatal form of cancer). In my view, determining an utterance's status as a 'lie' is not dependent on external factors (such as an explicit request or the 'success' of the lie) although of course this is not necessarily so of its *moral* status. The GP may well have been morally justified in lying to the old man.

Concealment and deception

Although lying does not, in my view, rely on an expectation condition to qualify as a lie, withholding information *does* rely on such an expectation to count as deception. At any one time, people hold hundreds of false beliefs. They do not, however, expect others to correct them unless there is good reason to do so. Just as we hold many false beliefs about the world, so do we withhold true beliefs from others. Since there is generally no expectation to reveal those true beliefs, it would be odd to say we are concealing them from others, let alone that we are deceiving them. Benn writes that an agent only deceptively conceals 'if the context is such that, were it the case that *p*, people could reasonably expect me [the agent] to reveal that *p* [...]'[29](p.132).

Under my chosen interpretation, determining whether an act of concealing is *intentionally* deceptive will rest on 1) the agent's intention, 2) people's reasonable expectations in the circumstances and 3) the success of the attempted deception. If I invite the nosy Jones to my house for dinner, expecting that he will want to peruse my collection of rare books on Mongolian dung beetles, and consequently hide my books in the attic, have I (intentionally) deceived him? As long as I succeed in concealing the books, the answer will depend on my intention and whether Jones' expectation to inspect my books is reasonable.* If his expectation is not reasonable, then my

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* In the sense used here, an expectation is 'reasonable' if it is supported by good reasons as judged from an external perspective. Subjective beliefs about the reasonableness of an expectation do not

concealment is not deceptive. If so, then it is. If I believe, falsely, that his expectation is reasonable, I am not deceiving him but merely *think* that I am. This interpretation appears more plausible than one relying on the agent's subjective belief about what the target reasonably expects. The following exchange can test out the intuitive appeal of the two possible interpretations:

Smith: "I hid the books from Jones, although I knew he wanted to see them. I deceived him!"

A: No, you didn't. He didn't have any right to see your books.
B: Yes you did, but he didn't have any right to see your books.

The first answer (A) represents my preferred interpretation of deception. Answer B represents the interpretation relying on the *perceived*, rather than the actual, reasonableness of expectation.

Reasonable expectation

To gain a clearer understanding of the phrase 'reasonable expectation', I will briefly examine the notions of 'expectation' and 'reasonableness'.

Whilst an expectation can be merely descriptive (e.g., I expect to come last in the race because I am unfit), the expectation in the proposed definition of deception (see below) is normative, indicating that the 'expector' believes the speaker *ought* to disclose the information. Since it is normative, a failure to meet this expectation would generally be met with disapproval by the expector.

An important point relates to the meaning of the phrase 'the target's reasonable expectation [of truthfulness]'. This does not mean, as Paprzycka notes, that the target actually *does* expect me, the agent, to be truthful[30](p.75). He may not expect anything. Rather, it should be understood in the conditional sense: "If the target were to expect of me that I tell him the truth, my target's expectation would be reasonable"[30](p.75).

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entail that the expectation really *is* reasonable. One can be mistaken about the reasonableness of one's beliefs or expectations. The notion of 'reasonable expectation' is discussed in the section below.

The notion of reasonableness can be divided into two distinct concepts: agent reasonableness and normative reasonableness[30](p.79). The first relates to the logical or physical feasibility of an expectation; the second to the appropriateness of the expectation. Expecting a patient in a persistent vegetative state to give informed consent is clearly unreasonable in the former sense (the patient is incapable of consenting), whereas expecting a patient to clean all the hospital toilets is unreasonable in the latter sense (while the patient could in theory do such a thing, it would be inappropriate to expect him to do so). The proposed definition of deception uses reasonableness in this last sense.

The appeal to '(normative) reasonableness', by referring to an external standard of appropriateness, serves to invalidate the normative force of inappropriate expectations (such as John's expectation to look at my books, in the earlier example). If John's expectation of truthfulness is based on irrational beliefs, for example, then I am under no obligation to meet his expectation.

Deciding whether or not an expectation is (normatively) reasonable, then, will rely on the strength of the reasons for and against the expectation. Paprzycka writes that 'because an expectation involves placing a demand on another person, such a demand must be justified and weighed against various kinds of considerations'[30](p.85). That these considerations may not be known to the expector does not, in my view, diminish the reasonableness of the expectation. The considerations exist whether or not the expector is aware of them. For this reason, reasonableness can be interpreted from an external standpoint. The dim-witted John can think his expectation of a salary rise is reasonable when in fact his absenteeism and substandard performance at work make such an expectation unreasonable. In this case, John *thinks* (mistakenly) that his expectation is reasonable.

Invoking external reasons to justify the reasonableness of an expectation is unlikely to yield clear-cut answers in all cases. There may be situations, as in moral dilemmas (see chapter 3), where more than one expectation is reasonable. There may also be disagreements over what constitutes a reasonable expectation, due to agents holding different (or differently prioritised) moral or cultural values. For this reason, calling an act 'deception' is not as straightforward as calling an act of coughing 'coughing'.

Little interpretation is needed to recognize an act of coughing, whilst labelling an act 'deception' needs to be justified by appealing, in part, to the reasonableness of the agent's expectation and thus to the reasons supporting the expectation.

Although the example I offered earlier (of the nosy John and the dung beetles) deals with deception by omission, the notion of 'reasonable expectation' can also be applied to deception by commission (i.e., where the deceiver actively says something to cause the desired belief). A doctor who enthusiastically tells his dying patient "I have seen people with your condition completely recover!" without mentioning that he has only seen two cases in his long medical career may be deceiving the patient if one could reasonably expect this last piece of important information to be shared.*

The decision to include the notion of reasonableness acknowledges the moral dimension of deception, in particular its *prima facie* wrongness. It also stresses the highly contextual nature of deception. As I will elaborate in chapters 3, 4, 8 and 9, a reasonable expectation of truthfulness need not always be respected, but can be justifiably overridden in certain circumstances. The overridability of the prima facie prohibition against deception will be shown using philosophical arguments, and supported by empirical data.

Settling on a definition

As the discussion above shows, defining deception is an arduous task. Ekman and Galasiński's efforts to redefine the term do not, I have argued, settle the definitional question. Galasiński's reliance on 'manipulation' creates as much as it resolves problems and Ekman's suggestion that all traditionally deceptive acts are in fact 'lies' fails to draw distinctions between clearly different types of deceptive strategies.

Although I initially attempted to arrive at a definition of deception which included no morally laden terms, I eventually changed my mind. The notion of 'reasonable expectation [of truthfulness]' seemed essential to capture the meaning of deception.†

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* I owe this example to Raanan Gillon (personal communication, October 17, 2005).

† The notion of 'reasonable expectation' is also relevant to aspects of US law, notably eavesdropping and privacy. In Katz v. United States (389 U.S. 347 (1967)), the Supreme Court ruled that FBI agents

This inclusion adds a more objective dimension to deciding whether an act is or is not intentionally deceptive. As mentioned earlier, it also introduces a *moral* element to the definition since finding others' expectations reasonable or otherwise ultimately requires making moral judgements. Deciding that Jones' expectation to peruse my books is unreasonable may be based on the further belief that Jones has no right to do so and thus that it would be neither wrong nor deceptive to hide my books.

With some trepidation, I thus propose the following definition of deception:

Deception (d): deception is a communicative act intended to induce or maintain what the agent believes to be a false belief in the target when 1) the target's expectation of truthfulness is reasonable and 2) the agent is successful in producing the intended deceptive outcome.

Perhaps less confusingly: "I deceive John if I intend to induce or maintain what I believe is a false belief in John when John expects me, with good reason, to be truthful and I succeed in inducing or maintaining that perceived false belief."

I do not claim the definition to be watertight. Although I opted to include the second clause -- the 'success condition' -- into my definition, thereby distinguishing between attempted but unsuccessful deception and successful deception (in much the same way as attempted murder is distinguished from murder), I acknowledge that others may not view a successful outcome as a necessary condition for deception. Under this last interpretation, an act or omission that is intended to deceive is sufficient to label that act as 'an act of deception' even if it fails to deceive. My suggested account of intentional deception, on the other hand, requires both an intention to deceive *and* a successful outcome. The advantage of this definition is that it can account for semantically odd sentences of the type "I was deceived, but wasn't fooled" or "I deceived him about the location of the treasure but he didn't believe me", which surely prompt the responses "so you weren't deceived/didn't deceive him!". These examples lend support to the 'success condition' included in my definition. While the

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who attached a listening device to the exterior of a public telephone booth to record the conversations of someone unlawfully transmitting gambling information to other States was unconstitutional. The Court agreed that the petitioner's reasonable expectation of privacy was violated and, in the words of Mr Justice White, that the petitioner 'spoke under circumstances in which a reasonable person would assume that uninvited ears were not listening'. Available online: http://caselaw.lp.findlaw.com/scripts/printer_friendly.pl?page=us/389/347.html [accessed 22/11/2005]. I thank Ronald P. Sokol for pointing this out to me.

issue may be of theoretical philosophical interest, for the purposes of this thesis, I do not think much rides on which of these two interpretations is preferred.

How does the proposed definition cope with the problematic gun-toting criminal example of p.18, where I direct the distrustful pursuant in the right direction by pointing the opposite way? Assuming I successfully direct him in the right direction, the definition rules that I did *not* deceive the pursuant about the fugitive's whereabouts (since I did not intend to induce a false belief about this) but I did deceive him about my intention, which he falsely believed was to lead him *away* from the fugitive. In my view, this is not a counterintuitive result.

A Gricean approach: communication, cooperation and deception

As my primary concern is with the acceptability of deception in the medical context, I shall not dwell on the different possible conceptualisations of deception. This would take us too far from the subject at hand. Instead, I shall examine the theory developed by McCornack, based on the work of Grice[31 32].

In 1975, the philosopher H.P. Grice published 'Logic and Conversation'[32]. In his paper, Grice argued that successful conversation is guided by an overarching 'Cooperative Principle' (CP). When we talk to people, we expect them to abide by certain rules of conversation. Consequently, any covert violation of these rules would be deemed uncooperative and potentially misleading. What, however, is the basis for the CP? Grice first notes that, as a matter of empirical fact, people *do* abide by such a principle. Not satisfied by what he calls a 'dull but [...] adequate answer', Grice searches for an explanation that would it make 'reasonable' for people to follow the CP. He tentatively proposes the following:

> [...] any one who cares about the goals that are central to conversation/communication (e.g., giving and receiving information, influencing and being influenced by others) must be expected to have an interest, given suitable circumstances, in participation in talk exchanges that will be profitable only on the assumption that they are conducted in general accordance with the CP and the maxims[32](p.49).

Reasonable people, intent on understanding and communicating with others, thus have good reason to adhere to the CP. Chapters 3 and 4, which discuss the truth-bias,

the value of truth and the ethics of deception, elaborate on the reasons for following conversational rules.

The Cooperative Principle and conversational implicatures

The Cooperative Principle consists of four 'categories': quantity, quality, relation and manner. In brief, the category of quantity relates to how much information to provide to your speaker. Ideally, one should be neither more nor less informative than is appropriate in the circumstances. Quality relates to the truthfulness of one's assertions. One should try to say what one believes to be true and avoid saying what one believes to be false. Relation relates to the relevance of the utterance and is encapsulated in the maxim 'be relevant' (to what is being said). Finally, manner relates to the clarity of the message. One must be clear and avoid obscurity or ambiguity. In normal circumstances, when we converse with someone, we assume that the speaker will abide, at least in intent if not in actuality, by these four categories.*

If, at first, an utterance appears to violate a maxim, the hearer attempts to derive plausible *conversational implicatures* to realign the statement with the Cooperative Principle. This is why certain speech acts, such as sarcasm, are not taken at face value by the hearer. Here is an example of a conversational implicature from Grice himself: A says "Smith doesn't seem to have a girlfriend these days" and B replies "He has been paying a lot of visits to New York lately"[32](p.51). B's statement, if taken literally, is violating the maxim of relation ('be relevant') as it is seemingly unrelated to A's assertion that Smith has no girlfriend. To make B's comment meaningful, we assume that B has conversationally implicated that A might actually have a girlfriend in New York, hence his recent trips there.

It is clear, also, that the violation of one (or more) of these maxims may in some circumstances be exploited to mislead the speaker. B, for example, may have said this to trick A into believing that Smith has a girlfriend. In fact, B knew that Smith was travelling to New York for business. In this case, B would also be violating the

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* Grice does not claim these four categories to be exhaustive. After listing the categories, he writes: 'And one might need others'[32](p.46).

maxim of quantity by failing to specify the reasons for Smith's trips to New York. Note also that A did not lie. The deception occurred without recourse to violating the maxim of quality but by manipulating other maxims. W.E. Forster is said to have asked 'What is the use of lying, when truth, well distributed, serves the same purpose?'[33](p.46). In the deceptive scenario above, the violation differs from, say, sarcasm in its subtlety. The deceiver will not accompany his violation with ostentatious facial contortions or tonal variations to indicate his intent. The violation is covert. It is this covertness which differentiates lies and other forms of deception from jokes and sarcastic comments.

An additional point relates to the dependency of the Cooperative Principle (CP) on socio-pragmatic factors (i.e., on the social context in which the assertion is made). One cannot ascertain whether an utterance is too short or too long (violating the maxim of quantity) without knowing what is expected or typical in the circumstances. External factors thus define the nature of the CP. A Scottish fisherman's understanding of the CP may differ from that of a Japanese businessman. The categories themselves may be identical, but their content may differ substantially. As a result, an utterance that may be seen as violating the maxim of quantity in England may not be among the Gbeya people of the Central African Republic, for whom the level of adequate information-giving may be lower.

Information Manipulation Theory (IMT)

McCornack has attempted to conceptualise deception by using Grice's CP[31]. McCornack's Information Manipulation Theory (IMT) is based on the claim that 'deceptive messages function deceptively because they covertly violate the principles that govern conversational exchanges'[31](p.109).* McCornack is not so much interested in the definitional aspects of deception but focuses rather on the *forms* of the deceptive message itself and the ways messages are manipulated to deceive the listener. Yet not all violations of the CP are deceptive. A speaker, through social ineptitude, can waffle irrelevantly when asked a question (violating the maxims of

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* Although I earlier argued that manipulation is not a useful concept in defining deception, IMT does not attempt to define deception. Rather, IMT serves as a tool to systematically analyse deceptive messages. It is not concerned with what deception is, but with how it can occur.

quantity and relevance) without intending to deceive at all. His prolixity might be terribly boring, but not necessarily deceptive. Verbal deception is merely a sub-class of uncooperative acts brought about by violations of Gricean maxims. Although IMT has been criticized on many fronts, it provides a useful framework for analysing *how* messages can deceive the recipient[34].*

Like the four principles of medical ethics, the four categories of the CP allow us systematically to examine cases of deception in everyday life and, in our case, in the doctor-patient interaction. Novack *et al.* suggested that 'physicians may have differing attitudes about the relative acceptability of the different forms of deception'[22]. IMT provides a descriptive tool with which to dissect those different forms.

Both McCornack's IMT and Grice's CP indicate why intentional deception should be considered prima facie morally wrong: deception takes advantage of people's reasonable expectations that the rules governing conversation will be followed. In this sense, intentional deception is uncooperative, violating a kind of implicit contract binding interactants to be honest in normal circumstances. But in what circumstances, if any, can deception be permitted and why? When is it acceptable deliberately and covertly to violate the CP? Chapters 3 and 4 attempt to answer these questions from a theoretical perspective, while chapters 8 and 9 address them from an empirical viewpoint.

Lies

As Barnes observes, 'lying is a slippery concept'[23](p.10). Barnes acknowledges the diversity of definitions of a 'lie' and concedes that, 'like Humpty Dumpty', he will select the definition which he prefers, namely that of Sissela Bok[23](p.11). A lie, according to Bok, is 'any intentionally deceptive message in the form of a statement'[9] (p.13). This definition, however, captures too much. To use an example by Bernard Williams, if I open a colleague's mail while he is away on holiday and, upon his

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* McCornack himself acknowledges the limitations of IMT: 'one of the HUGE limits of Grice is that nonverbals aren't touched much, and [...] you can SAY certain words but EMPHASIZE them in certain ways that cause entirely different inferences to be generated.' (his emphasis) (McCornack, S., personal communication, February 19, 2005).

return, tell him that "someone has been opening your mail" with the intention of misleading him into thinking it was someone else, then -- by Bok's definition -- I am lying[35]. Most people, I suspect, would not consider such a statement to be a lie, even if the statement clearly is intentionally misleading. Some may prefer to call it a 'half-truth' or 'being economical with the truth'. Williams revises Bok's interpretation as follows:

> **Lie:** an assertion, the content of which the speaker believes to be false, which is made with the intention to deceive the hearer with regard to that content[35](p.96).

Under Williams's definition, "someone has been opening your mail" is no longer a lie, since the speaker does not believe the assertion to be false.

Chisholm and Feehan believe that lies need not be stated or asserted verbally, but that an agent can lie to others by nodding, gesturing, writing, using sign language or smoke signals[36](p.11). The communicative force of these non-verbal acts, in the right contexts, can qualify as an assertion.* In the case of self-deception, Barnes also believes in the possibility of a lie without the production of a statement or utterance. A lie, under Barnes' definition, can also be thought[23](p.11).

Echoing Galasiński's scepticism about defining 'deception', Robinson announces at the outset of his volume on deception that 'any hope that there might be consensus about the definition of the word lie must be abandoned quickly'[37](p.28).† Robinson's concession is supported by the work of the linguists Coleman and Kay, who showed that people hold different interpretations of the word 'lie'[38]. With this in mind, it may seem pointless to ask -- as I did -- the various stakeholders whether they consider lying worse than acts of deception that do not involve lying, since each respondent may rely on a different definition of lying. To be accurate, I would first have needed to elucidate what each respondent understood by 'lying' before proceeding any

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* Much can be said about the definition of 'assertion'. A nod, for example, in response to a question may constitute an assertion. I have decided not to embark on a forensic examination of the term as a formal part of this thesis, but I briefly explore the notion in appendix B (p.311).

† Adding to the definitions of Ekman, Bok and Williams, Nyberg argues that a falsehood is not a lie if the hearer (e.g., a ruthless assassin) has not right to expect to be told the truth. A lie, for Nyberg, requires that the 'other person has a right to expect you mean what you say'[33](p.50). This unusual interpretation of lying does not appear to fit with the common understanding of the term.

further. This, however, seemed inappropriate in the context of a project more concerned with medical ethics than semantic linguistics or the philosophy of language.

One way to resolve this difficulty would have been to provide respondents with a hard-and-fast definition of lying and instructed them to refer to the definition when answering the questions. This would have ensured that all respondents shared a common definition of a key term. I decided against this method, as it would have added an unnecessary and possibly counterproductive layer of complexity. Some respondents may have been confused by this definitional constraint and provided answers which would not have reflected their true beliefs. Instead, I used Bernard Williams's definition (see p.30), which is a variant of what Coleman and Kay call the 'prototype' definition[38].

Prototypical lies

Coleman and Kay state that a prototypical lie is characterized by three 'prototype elements':

1. The proposition (P) is false.

e.g., *The car is blue* (whereas the car is in fact white)

2. The sender (S) believes P to be false.

e.g., *I believe that the car is not blue*

3. In uttering P, S intends the addressee to believe P.

e.g., *I intend to make my addressee believe that the car is blue by saying that it is*[38](p.28)

Williams's definition replaces 'uttering' with the semantically broader 'asserting' in 3)[35](p.96). This may indicate that, like Chisholm and Feehan, he believes that people using sign language or gestures can still 'lie'[36](p.149). For example, a person who shakes his head from side to side (in cultures where this signifies a negative response) when asked a yes-or-no question may, on Williams's definition, be lying if he intends to convey 'no' when he believes otherwise.

Williams's main modification, however, is the eradication of 1) -- 'the proposition (P) is false' -- which is also absent in Bok's definition of lying[9](p.13). With Williams, I

believe the truth value of an assertion is irrelevant to its status as a lie. Smith can tell Jones that the moon is made of blue cheese without being properly accused of lying, as long as he truly believes that the moon is made of blue cheese. He may be an ignoramus, but not a liar. Similarly, given the appropriate beliefs, Jones can lie to Smith by informing him that the moon was not a perfect sphere but an uneven geoid, even though this is factually correct[39].* Labelling an assertion as a lie rests more on the *intention* and *beliefs* of the speaker than on the truth or falsity of the assertion.

I thus accept Bernard Williams's definition of a lie:

Lie: An assertion, the content of which the speaker believes to be false, intended to deceive the hearer with regard to that content.

Does this definition match the common understanding of the word 'lie'? After all, there is much to be said for using a definition that the vast majority of laypersons recognise, all the more so in a study which relies on people's own definition of the term. Coleman and Kay's insightful study on people's understanding of 'lie' may help answer the question[38].

The authors devised eight stories in which one character 'lied' to another, each time from a selfish motive. As the purpose of the experiment was to discover whether respondents considered 'lies' which satisfy all three prototype elements as 'purer' lies than those satisfying less than three, each story involved a 'lie' with a different configuration of the three elements. The 67 respondents were asked to rate the lie from a seven-point scale with *very sure a lie* (7) at one end and *very sure not a lie* (1) at the other. Unsurprisingly perhaps, the more prototype elements a story contained, the higher the 'lie' score it received. The story containing all three elements received an average score of 6.96 out of seven[38](p.33).

Williams's definition of 'lie' contains two of the three prototypical elements, namely that the liar must believe the assertion to be false and that he intends to make the addressee believe the assertion. Coleman and Kay tested the popularity of the definition by means of the following story:

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* A geoid refers to the shape of the earth if measured at mean sea level.

> One morning Katerina has an arithmetic test she hasn't studied for, and so she doesn't want to go to school. She says to her mother, 'I'm sick'. Her mother takes her temperature, and it turns out to Katerina's surprise that she really is sick, later that day developing the measles. Did Katerina lie?[38](p.31)

The mean score was 5.16, second only to the story containing all three prototypical elements, and within the 5 to 7 parameter which represents 'lie'.* As to the order of importance of the three prototypes, the authors found that 'S believes P to be false' was the most important element, followed by 'S intends addressee to believe P'. The least important element was 'proposition P is false', which is the feature omitted from Williams's definition. Furthermore, the authors stressed that some respondents added personal interpretations to the case, such as personal experience of feeling unwell before exams, the gradual development of illness affecting behaviour, or a reluctance to accuse a sick child of deception. These interpretations may have lowered the mean score. Be that as it may, Coleman and Kay's study suggests, empirically, that Williams's definition does fit with the common understanding of the word 'lie'.

In the above study, participants tended to interpret the lies beyond the immediate context of the stories by projecting real-world information -- such as the likely relationship between the protagonists or the probable consequences of the lie -- onto them. There was an interpretive element which, according to the authors, seemed likely to affect the perceived nature and severity of the lie[38](p.40). In their discussion, Coleman and Kay suggest that people use words such as 'lie' with two considerations in mind. The first relates to how closely the term fits with the 'semantic prototype', or in this case the three prototype elements (falsehood, belief in falsehood, intent to deceive). The second relates to an awareness or knowledge of extra-linguistic factors which may affect the use of the term, such as connotations, reasons behind using the term, and in particular, a moral evaluation of the act. The authors comment:

> A frequent reason for reporting something as a lie is that we want to blame or criticize the person who said it; i.e., there is a strong association between a SENTENCE of the form X *lied* and an ACT of the (presumed) form 'I hereby blame/criticize/etc. X[38](p.37).

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* Respondents were aware that scores of 5 and above constituted a 'lie'.

It would seem, then, that the term 'lie' connotes blameworthiness or reprehensibility and that these negatively evaluative features may for many be ingrained within the term itself.

Conclusion

I have, in this chapter, tackled some of the issues surrounding the concepts of deception and lying. After evaluating various possible definitions of deception, I tentatively offered the following account: 'deception is a communicative act intended to induce or maintain what the agent believes to be a false belief in the target when 1) the target's expectation of truthfulness is reasonable and 2) the agent is successful in producing the intended deceptive outcome'. Once equipped with a definition, I suggested that McCornack's Information Manipulation Theory, based on Gricean maxims of conversation, may be used as a framework for examining deceptive messages. Deceptive messages can be analysed as a violation of one or more conversational maxims.

Finally, I turned my attention to what is considered the prototypical form of deception -- lying -- and proposed to use Bernard Williams's definition of a lie: 'an assertion, the content of which the speaker believes to be false, intended to deceive the hearer with regard to that content'. In the next chapter, I move away from the conceptual and linguistic intricacies of deception *tout court* to focus more generally on the moral philosophy of truth-telling and deception.

CHAPTER 3

Moral Philosophy of Truth-Telling and Deception

Most of the time, two people engaged in a conversation assume that each will speak the truth. This assumption, essential to successful human communication, is sometimes referred to as the 'truth bias'[21](p.ix). Grice anchored this bias on the maxim of quality, which requires a speaker to be truthful in the course of a linguistic exchange[32]. The philosopher Sissela Bok referred to the same assumption when invoking a 'principle of veracity'[9](p.30).

Whatever its theoretical underpinnings, the truth bias possesses a vital social function. A society lacking the bias would rapidly collapse under mass confusion. As individuals, we rely on truthful information to make rational decisions about our lives. If the driver of the car in front of us indicates a right turn, we believe that this is what he will do. We do not expect him to turn left. Without truthfulness, interpersonal trust would be impossible and without trust, all activities involving human communication would be severely undermined. It is not surprising, then, that the 'truth bias' is culturally non-relativistic and, in all likelihood, applies to each of the world's natural languages. Indeed, even liars need truth-telling to be the norm for their trickery to work. The success of their deception relies on the common expectation that, in the vast majority of cases, people will be consistently truthful to one another.

Yet, however central to the smooth running of society, the truth bias is no more than a bias. Deception, under a range of guises, appears ubiquitous in everyday discourse. One study by Patterson and Kim estimated that 91% of Americans are regular liars[40](p.45). Be it in politics, the media, sport, literature, or in our daily lives, many of our utterances are far from truthful[21 26 40 41]. Every year, millions of parents in the Western world deceive their children about the existence of Father Christmas and the Tooth Fairy. The inability to deceive has even been linked with psychological abnormality. Autistic children, for example, appear to be unable to lie or conceal information and some psychiatrists have considered a child's first lie as a major step towards social awareness and autonomous individuality[42-44]. In medicine, doctors

occasionally tell their child (and even adult) patients that a procedure "won't hurt" when they know it will. In many contexts, deception is considered little more than trivial or inconsequential (e.g., 'white' lies), yet in other situations it attracts near-universal opprobrium[45].

At times, deception is seen as positively desirable. In personal relationships, for example, the honest truth about a partner's unpalatable but laboriously prepared dish or a new but unsightly dress may be wounding to the recipient's feelings and potentially damage the relationship. A guest who tells the host that the dinner was inedible is likely to be viewed negatively by most people in our society. Many people are quite willing to deceive in order to protect others from emotional turmoil. In 1929, the International Herald Tribune recounted the true story of a mother whose family had concealed news of her son's death until her own death, ten years later[46]. Although her son, Robert, died in France from war injuries, her relatives told her that he was still living abroad. Until her death, her remaining sons regularly wrote letters impersonating Robert. She never found out the truth. Although many would view such extended deception as morally unacceptable, absolute veracity is not necessarily an ethically desirable goal, nor is it widely perceived to be[41].

Moral philosophers on truth-telling and deception

Whatever the prevalence and popular perception of deception in society, moral philosophers have long been concerned with the normative question of when lying is justified and the moral differences between lying and other types of deception. With regards to lying, two types of tension emerge from a review of the philosophical arguments. The first is between absolutist and non-absolutist positions.

Richard Norman defines moral absolutism as 'the view that certain kinds of actions are always wrong or are always obligatory'[47]. Thus a moral absolutist might condemn lying (or any act) as morally wrong regardless of the circumstances, even if the likely consequences of the lie appear highly beneficial. An agent who lies to free a hundred children from a ruthless kidnapper would still be committing a moral wrong, although other factors -- such as saving innocent lives -- may attenuate the badness of the act. The rationale underpinning the absolutism, however, is not fixed. The moral

absolutism of Kant, for example, rests on fulfilling the inviolable demands of the Categorical Imperative (CI). By lying, Kant claimed, an agent would run counter to formulations of the CI and, as the CI is the supreme principle of morality deriving from reason itself, lying must be categorically and imperatively avoided[48](p.14-15)[49](p.65). St Augustine's absolutism, however, is anchored on the idea that lying is unnatural for it goes against the God-appointed purpose of speech itself and the will of God 'from whose mouth nothing false proceeded'[50](p.253-254).

The non-absolutist, while he may accept that lying is at least prima facie wrong, will not consider lying as unquestionably wrong but will acknowledge the role of external factors or inner states, such as consequences or intentions, in the moral evaluation of the lie. Non-absolutists could therefore envisage situations where lying would be the morally right thing to do, since doing so would prevent the occurrence of harm or injustice or, for virtue theorists, would be what a virtuous person would do in the circumstances. For a consequentialist like Mill, for example, lying to an evil kidnapper to liberate a hundred children may not only be morally tolerable but positively required. Even a deontologist who is fervently opposed to lying may accept that, in desperate circumstances, lying may be permissible. So is the tension between absolutist and non-absolutist approaches to lying and deception irresolvable? Could the two sides negotiate a mutually satisfactory middle ground, or are the stances so firmly rooted that compromise is impossible? In this chapter, I shall argue that there exists a middle ground, and that the unflinching stance of absolutism can be undermined.

The second type of tension concerns the relative weight to be given to non-absolutist obligations. Once agreed that lying, in some circumstances, *may* be morally desirable, how do we decide whether or not we ought to lie in any given situation? Which factors should be given weight and how much weight should be attributed to each? This type of disagreement, which reflects a tension between one moral good and another, is more common in ethics and, arguably, more tractable. Agents can articulate reasoned arguments to resolve, or at least reduce, disagreements about the relative weight of the morally relevant elements. As such, it is more amenable to satisfactory outcomes, for the territory is generally more negotiable than in the bleak absolutist -- nonabsolutist case.

Reconsidering Absolutism

St Augustine, writing in the fourth and fifth centuries, was an early proponent of the absolutist position against lying and deception[50]. He argued that lying, which he defined as willingly uttering a falsehood for the purpose of deceiving, is *never* morally acceptable since 'to use speech [...] for the purpose of deception, and not for its appointed end, is a sin'[51] [52](chapter 22).* St Augustine rejected the anticipated retort that consequences may alter the wrongness of lying: 'Nor are we to suppose that there is any lie that is not a sin, because it is sometimes possible, by telling a lie, to do service to another'[52](chapter 22). Even if truth-telling will cause terrible physical harm to oneself (e.g., when it will result in serious assault or rape), the sinful status of lying means that purity of soul takes precedence over bodily purity[51] [54](p.506).

This said, Augustine did believe that certain factors and circumstances, such as lying to a terminally ill person to spare him suffering, may lessen the *badness* of the act (although it remains wrong). He divided lies into eight types, all wrong but of various degrees of badness. The range spans from 'deadly' lies, which are uttered in religious teaching, to lies that hurt no one but prevent the physical defilement of others[50]. In short, all lies for St Augustine are wrong but, depending on the intention of the liar and the consequences of the lie, they fall within a continuum of badness ranging from easily pardoned to abhorrent.† In the 13th century, Thomas Aquinas echoed the views of St Augustine, arguing for a sliding scale of badness based on intention: 'it is evident that the greater the good intended, the more is the sin of lying diminished in gravity'[55](p.257).

The ends of language

One may take issue with Augustine's interpretation of the 'appointed end' of speech. For many, speech itself was not 'appointed' by a supernatural being to fulfil a certain role. Neo-Darwinian scientists, such as Dawkins and Mithen, would argue that the first hominids developed speech as a result of genetic mutations allowing the

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* This is also the position of Thomas Aquinas: 'it is unnatural and undue for anyone to signify by words something that is not in his mind. [...] Therefore every lie is a sin, as also Augustine declares.'[53](p.1660).

† For a detailed exposition of St Augustine's views on lying and deception, see Ramsey, B.[54]

anatomical changes necessary for spoken communication[56 57]. In evolutionary theory, mutations are considered random errors[56]. By natural selection, the requisite genes will then have slowly disseminated throughout the population. Dawkins writes: 'Natural selection is the blind watchmaker, blind because it does not see ahead, does not plan consequences, has no purpose in view'[56](p.21). Incorporating the transmission of self-perceived truths as inseparable from the telos of language is thus question-begging. It assumes the existence of a seeing watchmaker.

Language, then, may have arisen randomly without a specific purpose. Attributing an original 'end' to language would then be committing a 'teleological fallacy'. Once equipped with language, however, man may have used this newfound tool for various purposes. Today, language may serve to impart information to others, to form, modify or maintain social relations, to influence others, to express and entertain ourselves, and to make sense of our experiences.

Lying, in certain situations, can achieve some, or occasionally all, of these ends as successfully as 'truthful' language, as long as lies do not so outnumber truthful utterances that reliable communication becomes impossible. Such an eventuality does not necessarily require the absolute prohibition of *all* lies. It only requires that truthfulness be the default option in the speakers' minds. Indeed, depending on one's interpretation of the ends of language, some lies may be considered desirable since they promote the ends better than the truthful alternatives. A lie, for example, may maintain a social relationship more successfully than a truthful statement.*

Kant's absolutism rests on the belief that rational beings have a constant duty to others, but also to *themselves*, not to lie, for lying 'violates the dignity of humanity in his own person' and is thus 'a crime perpetrated by man against his own person'[58]. Lying, which Kant defined as 'merely an intentional untruthful declaration to another person', is thus an absolute wrong on the grounds that it harms humankind generally and robs men of their dignity[59](p.269). In his *Lectures on Ethics*, Kant also affirmed the absolute wrongness of deception: 'In ethics, [...] every knowing deception, is

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* Writing from a social psychological perspective, DePaulo *et al.* assert that 'many of the same goals that motivate nondeceptive presentations also motivate deceptive ones'[41](p.979).

impermissible'[60](p.427).* According to Korsgaard, however, Kant's own writings are not *explicitly* absolutist about the rightness or wrongness of act-types (such as lying) but rather of maxims, which encompass both the act-type and the end (for example, lying to prevent distressing a severely ill patient).†

Lying and Kant's Formula of Universal Law

Lying violates the first formulation of Kant's Categorical Imperative (sometimes called the Formula of Universal Law), which states that I ought to 'act only according to that maxim whereby I can at the same time will that it should become a universal law'[48](p.30). When applying the test to determine whether an action is morally permissible, we should envisage a world in which everyone performs the action. Now, I cannot will that everyone else lie since not only would I not believe what others tell me but no one would believe the lie I am about to tell either. So willing that lying becomes a universal law would amount to willing the failure of my own lie, which is absurd. From this exercise, Kant concludes that lying is impermissible.

Kant claims that lying should be avoided since no rational being could accept that lying be a universal law[48](p.15). Yet, even if we accept the Formula of Universal Law (henceforth FUL), it may be possible, as Gillon points out in a personal communication, to rebut this position by arguing that there can be universalisable exceptions to the moral prohibition of lying. Elizabeth Anscombe, in her seminal article 'Modern moral philosophy', criticizes Kant for failing to appreciate this possibility:

> His [Kant's] own rigoristic convictions on the subject of lying were so intense that it never occurred to him that a lie could be relevantly described as anything but just a lie (e.g., as "a lie in such-and-such circumstances"). His rule about universalizable maxims is useless without stipulations as to what shall count as a relevant description of an action with a view to constructing a maxim about it[62](p.2).

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* The reader must bear in mind that there is some disagreement over how accurately the notes taken in Kant's lectures by his friends and students reflect his actual teaching. See [60](p.xvi). Indeed, some passages in the *Lectures* suggest he may not always have held such a rigorist position (see p.50 below).

† I thank Chris Korsgaard for pointing out the important distinction between act-types and maxims (personal communication, June 20, 2004). I have since found mention of it in Singer, M. *Generalization in ethics*: 'a reference to the circumstances and purpose of an action is necessarily involved in the "maxim" of the action.'[61](p.237).

So while no one would accept as a universal law lying to part elderly people from their meagre savings, they may not object to certain 'white' lies aimed at avoiding unnecessary offence or lies to save the lives of others. Indeed, certain 'white' lies seem to be accepted almost universally.

When applying the FUL, one must place the act A *in context* since A may be universalisable in one context but not the next. For example, if John, a precocious devotee of Kant's moral philosophy, is unsure whether or not to cheat in his exam, he will ask himself 'would I be ready to accept a world in which everyone cheated in exams?' Note that a negative answer would not invalidate cheating altogether but only cheating *in that particular situation.* If John, entangled in a bizarre situation, was required to cheat in his exam in order to save the world from a nuclear explosion, he may well accept a universalisable law permitting cheating to save the world.

One possible objection to universalising John's world-saving act of cheating is that this would amount to John willing the failure of his own cheating. To pass the test, the agent must envisage a world in which everyone performed the action in question. In such a world, however, John's cheating would be easily detected since, aware of the acceptability of cheating, people would anticipate his cheating. The universal practice of cheating to save the world would undermine the success of anyone trying to do so as the very efficacy of cheating relies on the unawareness of others. If X intends to dupe Y by cheating, but Y expects X to cheat, then X is unlikely to be successful in his attempt to dupe Y.

This seemingly powerful argument against the universalisation of cheating can, however, be countered. As Korsgaard notes, the validity of Kant's 'contradiction' argument rests on the assumption that whoever is the target of the deception is *aware* that the current situation permits deception[63](p.136). In my example, the invigilator must know that this is precisely the type of context in which cheating is acceptable. As the prohibition against cheating is the norm, this suspicion is unlikely. The maxim would thus contradict itself only if the invigilator is cognizant of the circumstances. The same applies to the case of the murderer at the door who asks for the whereabouts of his intended victim[63](p.137). As long as he does not identify himself as a murderer, he need not assume that the housekeeper will apply the universal law which allows

lying to a murderer in precisely these circumstances. If, however, the murderer believes that his addressee knows he is a murderer, then the FUL would reject the acceptability of lying in this case.

I have argued that lying (or deceiving) in certain situations could satisfy the FUL, as long as the formulation of the action is sufficiently specific and the deceived is unaware of the liar's precise understanding of the situation. John would be ignoring the complexities of the situation if, pondering whether or not to save the world by cheating, he simply asked 'would I be ready to accept a world in which cheating would be acceptable?' The immediate answer to the first question is 'no', but a second's thought reveals that a world in which cheating would *never* be acceptable may not be desirable either, as John's second case demonstrates. The likelihood that the accepted universal law would significantly alter the all-important truth bias is meagre indeed, since it is rare for people to be in John's unfortunate situation. With sufficient specification to account for the particulars of a situation, a universalisable maxim permitting lying is plausible.

One danger of applying the FUL, therefore, is conflating the morality of performing act A in situation φ with the morality of performing act A *generally speaking*. Applying this to the case of lying, a refusal to accept a world in which people regularly lie is distinct from accepting a world in which people lie in certain specific situations. In sum, the FUL is consistent with there being universalisable exceptions to the general rule against lying.

Many people will raise another objection to the FUL, namely that people *should* be permitted to lie to the murderer at the door, whether or not the murderer knows of their intention to deceive him. The murderer's state of knowledge about my own awareness of the situation should not affect the moral permissibility of the lie. It is neither here nor there, they would claim. The relevant facts are that a vicious murderer wants to slaughter an innocent victim hiding in my basement and is asking me for the latter's whereabouts. We have seen that Kant's counter-argument is that a universalisable maxim to lie in these circumstances would annul itself: in a world in which this was accepted, the murderer would see right through the deception. One possible counter to Kant's retort is that, for our purposes, we are interested in the

applicability of universalisable exceptions *in the real world*, not some projected, hypothetical world which bears no resemblance to reality. In effect, lying to the murderer would be permitted by denying the validity of the FUL.

It is probable that, in reality, the universalisable exceptions would work, if not all the time at least some of the time. After all, skilled magicians regularly deceive even the most sharp-eyed of spectators, however prepared the spectators may be! Even if lying to the murderer worked only 1% of the time, one could argue in favour of the rule on the grounds that it would save the life of at least one person. This is a contentious claim, which Kant would swiftly reject by invoking the principle of humanity and notions of personal responsibility, but one that I feel bears some weight against the FUL. The FUL relies on imagining a hypothetical situation in a projected world far removed from reality. The success of an act in Kant's imagined world will be quite different from its success in our world. The truth bias still remains despite the frequent and regular lies of speakers.* It is interesting to note, however, that Kant's objection to lying to the would-be murderer lies not in overriding the autonomy of the murderer, but in violating 'the universal laws of humanity':

> If anyone has defrauded or lied to me, then I do him no wrong if I defraud him or tell lies to him in turn; but I have done wrong in general according to the universal laws of humanity[60](p.193).

Lying and Kant's Formula of Humanity

When we lie, Kant would claim, we are also violating the second formulation of the Categorical Imperative -- the formula of humanity -- which states:

> Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means[48](p.36).

When we lie to someone, we fail to treat the recipient of the lie as an end-in-himself. By respecting a person's humanity, Kant means respecting that individual's free rational choice. A key passage in Kant's *Groundwork of the Metaphysics of Morals* illuminates the conditions necessary for treating someone as a means only:

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* "What if everybody deceived everybody else?" Nyberg asks in *The Varnished Truth*[33]. He continues: "The answer is, of course: everybody already does"[33](p.25).

> For he whom I want to use for my own purposes by means of such a promise [promising with the intention of not fulfilling the promise] cannot possibly *assent* to my mode of acting against him and cannot contain the end of this action in himself [...] he who transgresses the rights of men intends to make use of the persons of others merely as a means, without considering that as rational beings, they must always be esteemed at the same time as ends, i.e., only as beings who *must be able to contain in themselves the end of the very same action*[63](p.346) (emphasis added).

As Korsgaard explains in her analysis of Kant's interpretation of lying, treating someone as a mere means consists of the inability of the deceived to assent to the lie and the inability of the deceived of sharing (or 'containing') the same end as the deceiver[63](p.347). Even if it was somehow known that the deceived *would* assent to the lie (a patient might be known to be in favour of all benevolent lies, for example) the important point is that the deceived *cannot* do so in the face of a lie. He cannot possibly assent to the lie since he is unaware of it. Neither a post-factum assent nor an assumed assent alter the inability of the deceived to assent to the particular deception or its end.

If Jones, for example, lies about the cost of a cinema ticket he bought for me, then our ends differ. I believe that I am refunding him the true cost of the ticket whereas I am paying him more (or less) than this. My free rational choice -- or my 'humanity' -- has been violated. Now even if I later found out that Jones overcharged me and, considering Jones's dire financial circumstances, decided that I would have shared the same end, the act is still wrong since I was unable to rationally choose to pursue that end at the time. The same is true, mutatis mutandis, if Jones had undercharged me out of generosity. Jones's deception undermined my rational ability to affect the attainment of my end.

As long as rational agents are involved, the formula of humanity (FH), as interpreted by Kant and Korsgaard, does not seem to allow for exceptions to the rule against lying. However good the likely consequences or the motives underlying the deception, or indeed however universalisable the maxim, the FH forbids lies, deception and coercive acts as unexceptionable violations of a person's humanity. For Kant, 'to be

truthful (honest) in all declarations is, therefore, a sacred and unconditionally commanding law of reason that admits of no expediency whatsoever'[49](p.65).*

Kant's objection that deception restricts an individual's freedom is echoed by Bernard Williams and Joseph Kupfer, who stress the autonomy-reducing effect of deception[35] [64]. Deception, Williams argues, gives the recipient 'a picture of the world which is a product of my [the liar's] will' thus robbing the deceived of some personal freedom[35](p.118). Deceiving someone is, in effect, a type of theft; it is stealing the freedom to choose autonomously. Kupfer writes:

> *Immediate* restriction of the deceived's freedom is inherent in all (successful) lies because they limit the practical exercise of his reason: reasoning about possible courses of action[64](p.106) (his emphasis).

Nevertheless, this inherent restriction of autonomous choice is not a sufficient reason to hold an absolutist position against deception, although it justifies a presumption against the permissibility of deception. Neither Kupfer nor Williams argue for such an absolutist stance. Kupfer believes some lies, such as those which aim 'to defend one's (or another's) freedom' are justified[64](p.110) while Williams declares that 'there are all sorts of cases in which the best thing to do is to deceive'[35](p.121). Williams, like Grotius, believes some persons relinquish their right to be told the truth by virtue of their evil objectives[35](p.114)[65].† Referring to the Kantian scenario of the murderer at the door asking for the whereabouts of an innocent fugitive, Williams

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* Although, again, some passages in Kant's *Lectures on Ethics* suggest that Kant may at times have held more permissive views (see p.50 of this thesis).

† Grotius, the 16th century Dutch legal scholar, countered St Augustine's absolutism by invoking a right to be told the truth which could, at times, be breached[66]. He permitted the use of deception when that was the *only* way to save an innocent's person's life or for 'diverting another from the perpetration of some horrid design'[65]. He also allowed deception when used with children and madmen on the basis that these groups 'do not have liberty of judgement'[66](p.265). The right could also be relinquished by the other party's express or tacit consent.

> [...] the right [...] may be abrogated by the express consent of him with whom we are dealing, as when one says that he will speak falsely and the other permits it. In like manner it may be cancelled by tacit consent, or consent assumed on reasonable grounds, or by the opposition of another right which, in the common judgement of all men, is much more cogent[66](p.264).

Grotius thus endorsed the view that persons have a prima facie right not to be deceived which may, at times, be trumped by overriding considerations.

argues that 'anyone who had a sleepless minute over having told a lie to this murderer has [...] his Sincerity out of shape'[35](p.115).*

The italicised 'immediate' in Kupfer's extract indicates that deception may actually *enhance* autonomy in the long run, as when a doctor lies to prevent a patient from having a life-threatening heart attack or puts medication in a psychiatric patient's tea. Kupfer adds that lying may benefit the deceived by 'prompting him to think and choose intelligently for himself'[64](p.108). The immediate restriction of freedom inherent in deception is thus no more than a presumption against the act-type.

There are also times when we feel there is no need to obtain a person's consent. If I discover that Smith has stolen my computer, I am entitled to take it back whether or not he consents to it. Kant himself acknowledges that if I lie to another who has lied to me 'he himself can certainly not complain of me'[60](p.193). The wrongness of the lie, for Kant, is its violation of the duty to oneself and of the universal laws of humanity so essential to the proper functioning of society[58 60](p.193).

It also seems possible for a patient to ask his doctor to lie to him about an eventual bad prognosis, for example. If the anticipated situation arose and the doctor lied, the doctor could be said to have respected the autonomous wish of his patient. In the days before effective anaesthetics were used, patients often gave the surgeon consent to be coerced during the excruciating surgery. Although they would be pinned down by several people during the amputation and possibly begging for the surgeon to stop, it would be unreasonable to say that the surgeon acted without consent and that, as a consequence, he treated the patient as a mere means.

Parfit's Consent Principle and the Formula of Humanity

To account for some of the examples above, Derek Parfit proposes a Consent Principle which states that 'it is wrong to treat people in any way to which they could not have rationally given, in advance, their irreversible consent'(Moral Philosophy

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* By Sincerity, Williams means the 'disposition to make sure that one's assertion expresses what one actually believes'[35](p.96).

Seminar, Oxford, January 31, 2005).* In some of the cases above, the deception and coercion would be allowed under the Consent Principle as the patients in fact consented, in advance, to the acts. The Principle does not specify that the agent *must* have given prior consent but rather that the agent must have had *sufficient reason* to consent to the act. In the case of the amputation, the Principle may have permitted the coercion even without explicit consent (the patient would presumably not have accepted to undergo the life-saving operation otherwise). In other cases, applying the Principle may not be so easy.

Kant's formula forbids an agent to treat another rational being as a *mere* means. But what does it mean to treat someone as a mere means? Clearly, we frequently use people as means. When we take a taxi home, or use the cashier in the supermarket, we use people as means. We also use them as ends-in-themselves, however, in that they agree to be thus used in the pursuit of their own ends (e.g., their livelihood) and we use them in the knowledge of their implicit agreement. What difference does that 'merely' make? For Parfit, the adverb seems to reflect a particular *attitude* (Moral Philosophy Seminar, Oxford, January 31, 2005). For this reason, examining the act itself is insufficient to ascertain whether or not an agent is treating someone merely as a means. To be sure of this, we would need to delve into the motivations of the agent performing the act.

If I do not consider the taxi driver as an end-in-himself, then I treat him merely as a means, even if I pay the fare. I pay the fare only because I am legally required to do so, not because I wish to contribute to his financial well-being. If payment was optional or there was no law instructing me to do so, then I would certainly not pay him. Treating a person merely as a means is therefore treating that person *with the attitude* that he is not an end-in-himself. In an unpublished manuscript, Parfit exposes his interpretation:

> [...] we treat someone merely as a means if we both use this person in some way and regard her as a mere tool, someone whose well-being and moral claims we ignore, and whom we would treat in whatever way would best

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* In an unpublished manuscript, Parfit specifies that the Consent Principle will not be satisfied if the consenting agent is not in possession of key facts. He writes: 'we would be acting wrongly if we know that there are facts, unknown to these people, that would give them decisive reasons to refuse consent'[67](p.61).

> achieve our aims. We do *not* treat someone merely as a means, nor are we even close to doing that, if either (1) our treatment of this person is governed or guided in sufficiently important ways by some relevant moral belief or concern, or 2) we do or would relevantly choose to bear some great burden for this person's sake[67](p.77, p. 88) (his emphasis).

For Parfit, respecting the Consent Principle (i.e., treating people in ways to which they could rationally consent) qualifies as a relevant moral concern. Parfit's account suggests that deception is not necessarily using a person only as a means, as long as either a) the deceived would have had sufficient reason to consent prior to the act or b) the agent is putting himself to some considerable effort or at significant risk for the sake of the deceived, or *would* put himself at such risk if this were possible. Clearly, there may be cases of deception in medicine where a) or b) are satisfied. A doctor who lies to a patient to reduce the likelihood of rupturing an aneurysm even though the lie, if immediately discovered, could affect the patient's trust in the doctor and may damage his reputation is, on Parfit's account, *not* treating the patient merely as a means.

Although these conditions are inevitably vague, they seem closer to common sense morality than Kant and Korsgaard's belief that deception is invariably treating someone merely as a means. It seems to me that deception is treating someone as a means, but not necessarily as a *mere* means. A doctor's benevolent lie to a patient is treating the patient's credulity as a means to improve the patient's health, but the doctor is not using the patient as a mere means if he genuinely wants him to get better and believes the patient does too. He considers the patient as an end-in-himself, holds an interest in his well-being, and assumes the patient does too.*

Korsgaard's two-level theory of individual morality

Korsgaard attempts to remedy the implausibility of the Categorical Imperative's (CI) rigorous implications by suggesting a two-level theory based on Kant's formulas[63](p.151-154). She criticizes Kant's absolutist theory -- and other single-

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* I shall return to the application of Parfit's interpretation of 'mere means' to deception in medicine in chapter 4 (p.100-101).

level theories (such as some forms of utilitarianism) -- as wrongly relying on an ideal world and 'grotesque' accounts of personal responsibility[63](p.150). The Kantian who tells the truth to the murderer at the door, for Korsgaard, *should* be held responsible for the consequences of his revelation, although under the Kantian approach those consequences are outside his sphere of responsibility. The real world is not a Kantian Kingdom of Ends, where each person respects the other person's humanity and dutifully follows the CI, but, as I showed at the start of the chapter, a world abounding in lies, coercion, and other violations of the CI. In this non-ideal world, there may be instances where it is morally right to treat others merely as means. If a malfunctioning robot threatens to kill an innocent child and the *only* way to prevent this is, curiously, to smash a bystander's toe, then it may well be right to smash the man's toe *even though* you would be using that person merely as a means to save the child's life.*

It is desirable, however, to strive for an ideal world and in our daily lives we should follow the Formula of Humanity (FH). But when faced with great evil, Korsgaard argues, we can move to another, non-ideal level where we can justifiably violate the FH by treating people as mere means.

Korsgaard's less rigorous criteria, without a loose interpretation of what constitutes a 'great evil', still seems too stringent. The person who would rather tell a hurtful truth than a benevolent lie to an obese, tearful and depressed patient in need of comfort may have integrity but, in my view, lacks compassion[68](p.131). James Rachels's claim that the unflinching absolutist is 'guilty of an unfeeling heart' is an appealing one in such cases[69](p.210). Applying Kant's own FUL, envisaging a world in which nobody lies or deceives is a frightening exercise. I would certainly refuse to accept such a maxim on the grounds that it would have a detrimental effect on the social relations between persons. The Formula of Universal Law, on my interpretation, denounces lying while also denouncing the absolute prohibition of lying. There must be a middle ground between these two implausible extremes, where lying is acceptable under certain conditions.

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* This bizarre scenario is a slight variation of an example given by Derek Parfit in a moral philosophy seminar, held at Oxford University on January 31, 2005.

In Kant's *Lectures on Ethics*, there are a few indications that Kant himself was not a strict absolutist on lying.* At one point, he argues that:

> [...] since men are malicious, it is true that we often court danger by punctilious observance of the truth, and hence has arisen the concept of the necessary lie, which is a very critical point for the moral philosopher [...] So far as I am constrained [...] and I am unable to save myself by silence, the lie is a weapon of defence[60](p.204).

The passage suggests that, if faced with a credible threat to one's life and if silence will not avert the danger, then lying is a permissible way to protect oneself.†

Elsewhere in his *Lectures*, one finds another clue: 'The importance of the love of truth is so great that one can *almost never* make an exception to it'[60](p.27) (emphasis added). In notes made on his 1794 work *Observations on the Feeling of the Beautiful and Sublime*, one finds yet another indication of non-absolutism:

> In certain situations in life a lie [...] in accordance with the rule of prudence seems the thing to do, but for this there is required great acuity and sagacity concerning the consequences. [...] Even if a false assertion may sometimes be useful for others, it is still a lie *if no strict obligation necessitates it*[71](p.19) (emphasis added).

This last statement may suggest that a false assertion is not a lie if strict obligation requires it (such as saving one's life), and hence it may be morally acceptable. If so, Kant would remain absolutist by manipulating the definition of lying to exclude certain cases.

Many absolutists have ways to allow exceptions to their absolute rules. They use conceptual devices which render prohibited acts -- such as killing or performing an

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* Nonetheless, we should once again bear in mind that Kant did not write the lecture notes himself and that scholars disagree over how accurately they represent Kant's views[60](p.xvi).

† The view that lying is permissible in self-defense is also found in the writings of the utilitarian Henry Sidgwick, who argues the point through analogy:

> Just as each man is thought to have a natural right to personal security generally, but not if he is himself attempting to injure others in life and property: so if we may even kill in defence of ourselves and others, it seems strange if we may not lie, if lying will defend us better against a palpable invasion of our rights: and Common Sense does not seem to prohibit this decisively[70](p.273).

Sidgwick's argument can be viewed as a reductio ad absurdum: If one could intentionally maim or kill another person against his will to save others or oneself (thus treating that person merely as a means) then why should one not lie for the same reasons? The belief that lying is always wrong but that killing is only occasionally so is intuitively odd.

abortion -- permissible or pardonable in certain situations. Thus Aquinas, whose teachings have been greatly influential in Roman Catholic thought, invoked the doctrine of double effect to allow exceptions to the absolutist rule against killing the innocent.* With regards to lying, the stringency of an absolutist position on lying will rest on the chosen definition of what constitutes a lie. As Jackson notes, absolutists about the wrongness of lying tend to adopt a narrow definition of lying, whereas non-absolutists generally use broader definitions of lying[6](p.45). One way to justify what most people would consider lying is by appealing to the doctrine of 'mental reservation'.

The doctrine of mental reservation

The doctrine of mental reservation was developed by Doctor Navarrus (Martin Aspilcueta), a renowned moral theologian living in the 16th century[73](p.164). Popular in Catholic Europe during the 16th and early 17th centuries, the doctrine allowed people to utter outwardly misleading statements if they silently added a qualification in their minds to render the statement true. This silent addition, although inaudible to the addressee, would nonetheless be heard by God. According to Marshall, mental reservation represented a 'legitimate means of misleading an unjust interrogator, while remaining within the confines of an absolute Augustinian prohibition on lying'[74](p.363).† Although in the centuries to follow the doctrine was widely criticised and dismissed across Catholic Europe, it was still embraced by Charles McFadden in his *Medical Ethics*, first published in 1946[75]. In the 6th edition (1967), McFadden starts the chapter on truthfulness by announcing his absolutist position:

> Lying is so universally regarded as a degrading and detestable habit that there should be no need to remind doctors and nurses that it should have no part in their lives[76](p.389).

The rationale underpinning his absolutism is that lying is 1) intrinsically immoral because it is an abuse of a God-given faculty and 2) extrinsically immoral because it is socially disruptive. Nonetheless, using the example of a doctor or nurse faced with a question whose truthful answer would violate confidentiality, he suggests that 'the

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* For an account of the doctrine of double effect, see Beauchamp, T. and Childress, J.[72](p.129-132)

† This was also true of equivocation, which 'entailed the use of words or expressions with a double meaning different for the speaker than for the hearer'[73](p.163).

careful use of mental reservation will provide the solution to such difficulties'[76](p.391).

To illustrate the functionings of the doctrine, McFadden gives the example of a doctor who informs the patient that his temperature is normal, knowing that the patient will understand 'normal' as 'normal for a healthy person', whereas the doctor interprets 'normal' as 'normal for a man in the patient's present condition'. For McFadden, this is not a lie since the statement is not 'contrary to one's internal thought or conviction' and he concludes that mental reservations are 'a priceless asset in maintaining one's own moral standards, and it is often the best aid at hand for preserving inviolate the reputation of a patient from a prying questioner'[76](p.393). The strategy here is to modify the definition of lying to permit the act.

McFadden operates under an unusual definition of lying, namely one that does not contain the speaker's intention to mislead. A mental reservation is not 'lying' because, the argument goes, the addressee misleads *himself* by too hastily interpreting the assertion. McFadden's definition of lying restricts itself to assertions that are contrary to the speaker's thoughts.

Evaluating non-absolutist positions on deception

An intuitively plausible compromise would be to ascribe intrinsic negative value to the act of lying, but to allow this negative moral value to be countered if the benefits of the lie are sufficiently important to outweigh the wrong of lying. The *overall* value of lying is then determined not solely by its intrinsic value, but by also considering its extrinsic value. The lie itself may be wrong, but the act could, on balance, be permissible in light of countervailing benefits. Good judgement would be required to weigh the various considerations in a morally satisfactory manner. Although less convenient than the straightforward absolutist prohibition or a simplistic utilitarian calculus, this compromise seems more in line with the reaction we get when faced with the kinds of morally difficult scenarios presented in my questionnaire.* This approach assimilates in diluted form the revulsion of Kant and other absolutist

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* A copy of the questionnaire, with full versions of the scenarios, is appended in appendix C (p.313).

deontologists, while also taking into account the consequentialists' concerns with outcomes. It would also allow for moral 'residue' -- a feeling of remorse or regret for having violated the prima facie rule -- resulting from the lie[77](p.44). This kind of 'middle ground' position is favoured by intuitionists, such as W.D. Ross[78] [79](p.xxxv-vi and p.28).* I will return to intuitionism towards the end of the chapter. Some possible approaches of other moral theories to the issue of deception are briefly explored below.

Utilitarianism

John Stuart Mill's *Utilitarianism* condemns lying in most circumstances, since lies undermine 'the trustworthiness of human assertion, which is [...] the principal support of all present social well-being'[80](p.223). Mill in effect presents a rule-utilitarian objection to lying. A general condemnation of lying can thus fit within Mill's Greatest Happiness Principle. Of course, the prohibition is not absolute and Mill, echoing Grotius, gives the example of when 'the withholding of some fact [...] would save an individual [...] from great and unmerited evil'[65] [81]. In such a situation, a utilitarian would not merely be justified in lying but would be morally *required* to do so.

Brad Hooker defines act-consequentialism as the belief that 'the moral rightness of an act depends entirely on whether the act's consequences are at least as good as that of any alternative act'[82](p.183). Act-utilitarians may not view lying or deception so negatively as Kantian deontologists or rule-utilitarians. They may not necessarily start from the default position: deception is prima facie wrong. Lying, as an individual act, is neither necessarily good nor bad. Hence, all other things being equal, bringing about the good X by lying is equivalent to bringing about X by telling the truth. The act-utilitarian may approach each situation independently and assess the morality of deception based on the likely consequences resulting from it.

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* Ross explicitly stated his non-absolutist position on lying: 'as almost all moralists except Kant are agreed, and as most plain men think, it is sometimes right to tell a lie'. For Ross, the fact that an act is a lie merely indicates that it *tends* to be wrong[79](p.28).

An important point to note is that a utilitarian position need not differ radically from non-utilitarian positions. Deontologists may see lies as unacceptable violations of personal autonomy, and utilitarians may agree that, most of the time, this is undesirable and that respecting others is pivotal to social well-being. Utilitarians can also encourage acts that will foster traits of character, such as honesty, which are likely to contribute to the overall good. For utilitarians, as for deontologists, lying can be prima facie wrong. This may be the position of some rule-utilitarians, for whom the focus is on the consequences of a code of rules, rather than on particular actions[82](p.183). The primary difference between deontological and utilitarian positions on lying resides in the intrinsic moral (dis)value of the lie.

A two-level utilitarian, espousing the theory of R.M. Hare, will attribute a prima facie wrongness to lying, while allowing the violation of the rule against lying in certain, morally difficult cases[83].* For Hare, our moral reasoning is divided into two levels: the *intuitive* and the *critical*[83]. The intuitive level is the default level, in which our everyday actions are guided by internalised principles acting as 'rules of thumb'. Instead of weighing the pros and cons of every action, we simply follow the rules. At times, however, we are faced with difficult situations where our basic rules conflict or cannot yield a satisfactory answer. In these cases, we should move onto the second, critical level, where we should adopt the act-utilitarian position of a hypothetical, all-knowing, infallible 'archangel' who accurately balances harms and benefits in a state of perfect knowledge. Even in cases of justified lying, the moral agent should feel some moral residue at the violation of the first-level rule against lying.

In Bernard Williams's oft-cited case of Jim and the Indians, where Jim is offered the choice of killing one Indian to free nineteen others, or refuse and have everyone shot, the two-level utilitarian can account for Jim's reluctance to accept the offer even if, on balance, the benefits clearly outweigh the harms[84](p.98-99). This more sophisticated form of utilitarianism thus makes room for the feeling of regret which classical utilitarianism regards as irrational since lies, in that theory, are morally neutral. It reconciles the precepts of common sense morality with the coldness of classical utilitarianism.

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* Hare might be described as a sophisticated act utilitarian.

The utilitarian idea behind Hare's two-level theory is that agents will not, in general, produce the best outcomes if they strive to be archangels all the time. Not only would this be tremendously time-consuming and consequently harmful in situations requiring immediate action, but people are not archangels and will, as a result of their imperfections (especially their self-interest and their inadequacies in predicting outcomes), make mistakes. Hare's theory, however, suffers from indeterminacy. When, in practice, should an agent shift from the first level of rule-following to the second, act-utilitarian level? For our purposes, when should the 'rule of thumb' against lying be justifiably violated?

Although consequentialist positions on lying can be theoretically straightforward, Bok emphasizes the practical difficulties of calculating the consequences of a lie or a broken promise. She illustrates her point by examining a hypothetical scenario[9](p.51). In the scenario, a person (let us call him John) is stranded with a dying man on a desert island. John falsely promises his companion that he will donate his friend's gold to the prestigious South Australian Jockey Club. As the island is deserted, the promise is not overheard by anyone. Once rescued, however, John donates the gold to the Royal Adelaide Hospital, which desperately needs the money for a new X-ray machine. Was John wrong to act in such a way?

Whatever one's position on the issue, Bok stresses the fact that the lie *does* have negative consequences, even though no other soul may know of it[9](p.52). She mentions the 'risks to the liar himself of personal discomfort and loss of integrity, of a greater likelihood, however slight, of having to lie again to shore up the first lie; and of a somewhat diminished resistance to lying for causes he may wish to further in the future'[9](p.52)*. Besides, that single lie may generate further lies if people start asking questions about John's out-of-character donation to the hospital. Sir Walter Scott warned of the risk of this slippery slope in his verse from *Marmion*: 'Oh, what a tangled web we weave, when first we practice to deceive'[85]. St Augustine, like Bok, warned of the liar's diminished resistance to lying in his treatise *Against lying* and so

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* Kupfer also discusses the dangers of lying on the liar, and argues that lying misreprents who and what we are and thereby creates a potentially harmful barrier between the liar's true self and others. He concludes 'The social, linguistic isolation obstructs personality integration because social intercourse is needed to organize our opinions and know ourselves.' As I understand his argument, the idea is that truthful communication with others, by encouraging critical reflection about the validity of our beliefs, is essential for a better understanding of ourselves as moral agents. See [64](p.118-120).

too did Montaigne when he wrote in his essay *Of liars* that 'once the tongue has been put on this wrong track [lying], it cannot be called back without amazing difficulty'[50] [86](p.28). So although lying can still be justified on utilitarian grounds if the good consequences are likely to outweigh the bad, Bok highlights the importance of fully acknowledging the impact of a lie on the liar himself. This is no easy feat as liars tend to be biased in the moral evaluation of their own lies.

In some situations, even without bias, weighing the consequences of an act is highly speculative as the consequences themselves are far from certain. In the case of Jim and the Indians, can we be sure that the evil captain will keep his promise if Jim shoots an Indian? Maybe the slaughter of the villagers will generate a mass rebellion that will overthrow the tyrannical reign of the captain and bring peace to the community. Maybe Jim's refusal to kill the Indians will infuriate the captain and aggravate the situation for him and other villagers[87](p.76). In the case of lying to severely ill patients, similar doubts on the consequences of deception arise. A doctor's decision to deceive his patient will be based on anticipated consequences with various degrees of likelihood. So, within utilitarian theories themselves, disagreements can occur. Combined with agent bias, a consequentialist evaluation of deception is prone to error. It is precisely this inherent uncertainty regarding the consequences of certain actions that rule-utilitarianism and the first level of Hare's two-level theory attempt to overcome.

Rights-based theories

A rights-based theory is one whose basic principles are anchored on the concept of rights. Geoffrey Marshall provides a concise account of a right: 'A right [...] is obviously a form of entitlement arising out of moral, social, political or legal rules'[88](p.228). For Rachels, a personal right 'places limits on how an individual may be treated, regardless of the good purposes that might be accomplished'[89](p.108). A common ethical justification for the existence of human rights is that they are necessary for human flourishing or human interests. The rights are thus derived from some account of the good and of basic human needs[90](p.76). In their focus on the protection and promotion of basic human needs, rights are an intuitively attractive

proposition. The difficulty lies in establishing a satisfactory account of the good, and deriving from it a set of rights.

Recognising this difficulty, Onora O'Neill favours grounding rights on moral obligations[90](p.77). For O'Neill, referring to obligations is clearer than referring to rights, as obligations are more clearly connected to required actions and do not suffer from the fuzziness inherent in the concept of 'rights'. Whereas certain rights can appear to be 'ideals or aspirations', obligations specify action, since the language of obligation is tied to the language of action (i.e., one has an obligation to do/act/refrain, and so on)[90](p.81). Furthermore, an approach based on obligations, by stressing the nature of *relationships* between persons -- between the duty bearers and the right holders -- is less individualistic than rights-based approaches. For these reasons, O'Neill argues that it is best to derive rights from obligations rather than vice versa.

In the context of truth-telling and deception in the doctor-patient relationship, a rights-based theory might argue for the existence of a patient's right to know and thus a corresponding duty on the part of the doctor to inform the patient. Deception may represent a violation of the right to know.

Following O'Neill's advice on starting with obligations, it seems plausible to say that doctors *do* have an obligation to reveal certain information to their patients. The obligation to inform can be derived from more fundamental and accepted obligations, such as the obligation to respect the decision-making capacities of autonomous patients, to provide net benefit for the patient, or to avoid causing them net harm. If we accept that such a derivative obligation to inform exists, we can also accept that patients have a corresponding right to know. A duty to inform will also generate a more specific duty not to deceive.

Even if we accept the existence of a right to know, we would still need to specify how much information the patient is entitled to know.* The scope and limits of the right would need to be determined: a right to know *what* and *how much*? Sumner describes how rights possess strengths which indicate their 'level of resistance to rival

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* The idea of a 'right to know' is examined in the empirical part of the study (see p.185-187).

normative considerations, such as the promotion of worthwhile goals'[91](p.293). Hence, even if we acknowledge the existence of a right to know (or a right not to be deceived), its strength may be outweighed by competing moral duties, unless we consider it absolute.

Discussing the possibility of absolute rights, Brenda Almond notes that even very basic rights, such as the rights to life and liberty, may conflict with each other, thus suggesting that there are no absolute rights[92](p.266).* O'Neill, who believes in an obligation not to deceive (or coerce) derived from the need to maintain relations of trust, explicitly says that the obligation is not absolute, but that 'some forms of deception [...] must be accepted even by those whose fundamental principle is to reject deception'[92](p.98).

Despite the widespread use of the notion of 'rights' -- we hear of workers' rights, women's rights, social rights, human rights, children's right, patients' rights -- there is much debate over whether a theory can be solely rights-based, as rights must themselves originate from a deeper 'source' and may neglect certain areas of morality, such an environmental issues[92](p.265).

Contractualist theories

Contractualist theories are united by the common idea that moral obligations should be based on mutual agreement between reasonable persons. Under the contractualist theory of John Rawls, a just society is one which reasonable people could agree to if, from a hypothetical position which he called the 'original position', they did not know anything about the qualities they would have within that society[95]. They could be rich or poor, intelligent or slow-witted, thin or fat, and so on. When choosing, these reasonable people would be blinded by a 'veil of ignorance' which would prevent them from selfishly choosing social arrangements they would find advantageous.

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* A real life example of a conflict between two individuals' right to life is the case of the conjoined twins, Jodie and Mary. The twins were separated in November 2000 although it was virtually certain that one of the twins (Mary) would die as a result of the surgery[93]. In his conclusion on the case, Lord Justice Ward declared: 'Though Mary has a right to life, she has little right to be alive. She is alive because, and only because, to put it bluntly but nonetheless accurately she sucks the lifeblood of Jodie and her parasitic living will soon be the cause of Jodie ceasing to live. Jodie is entitled to protest that Mary is killing her'[94].

Under the more recent contractualism of Thomas Scanlon, the focus shifts from finding principles that reasonable people could agree to, to finding principles which no one could reasonably reject[96]. Hence, for Scanlon, an act is wrong when, and because, it is prohibited by a principle that no one given full information could reasonably reject[96](p.195)[97]. On the subject of reasonable rejection, Scanlon notes that, in many cases, 'gains and losses in well-being [...] are clearly the most relevant factors determining whether a principle could or could not be reasonably rejected'[96](p.215). The assessment of a principle should take into account the consequences of rejecting it *generally* (not only in a specific situation), including the likely costs to others. Furthermore, since we cannot possibly know which specific individuals will be affected by the decision, the assessment should rely on 'commonly available information about what people have reason to want'[96](p.204). The contractualist theories of both Scanlon and Rawls, by appealing to hypothetical standpoints and notions of reasonableness, thus emphasize the importance of reason and impartiality.

Under a contractualist approach to deception in medicine, a key question might be: would reasonable people agree on a moral principle permitting doctors' benignly intended deception in some circumstances? Although widespread deception in society would surely fail the Rawlsian test (since cooperation for mutual benefit would be impossible), it seems plausible, in theory, that self-interested rational agents could agree to embark on a social relationship with a specified rule permitting deception in certain circumstances. I have argued in this chapter that there are good moral reasons to reject an absolutist principle prohibiting deception. Some deceptions in medicine, such as those addressed to confused patients or patients who have made prior, autonomous requests to be deceived, can result in overall gains in well-being.

It is less clear, however, whether any deception could satisfy Scanlon's test (i.e., whether no one could reasonably reject a principle allowing deception). If, adhering to a Kantian interpretation of the CI, I believe all deception is morally prohibited, then is my rejection of the principle reasonable? In other words, how does one determine whether a moral agent's reasons are strong enough to reject the principle? Passing the test might also depend on the specificity of the proposed principle and on the comparative evaluation of the reasons supporting alternative principles.

There is an important problem with the contractualist approach, which relates to the criterion of rightness needed to justify a principle. If reasonable people agree on a principle permitting lying to terminally ill cancer patients, is that because such an act *is* morally right (for various reasons) and thus can be agreed upon, or vice versa? (i.e., *because* there is agreement, it is morally right). What makes an act right or wrong, it seems, must appeal to other, more fundamental reasons. Mere agreement does not appear to be sufficient.*

Virtue ethics

Although from a virtue theoretical perspective lying tends to be a vice, in some contexts, a lie may be considered not just morally tolerable but downright 'heroic'. The linguist Galasiński cites the Polish philosopher Józef Tischner who considered lies made to avoid betraying comrades or to dupe an enemy as acts of courage and heroism[21](p.120). The idea of lying as potentially heroic is conceivable for some proponents of virtue theory who see the rightness or wrongness of an action according to what a hypothetical virtuous person would do in the circumstances. Heroic virtue would be exercised in extremely demanding situations. In Germany, during the Second World War, many risked their own lives to protect Jews from the Schutzstaffel (SS), and some chose death by hanging rather than join the SS. These would be examples of heroically virtuous persons. As for heroic lies, I immediately think of Edmond Rostand's Cyrano de Bergerac, who altruistically lied to the dying Christian about who Roxanne, Christian's wife, truly loved and to Roxanne herself about the identity of the letter writer[99].

The virtue ethicist would presumably reject both the apparent inflexible rigorism of Kant ('never deceive') and the simplistic reductionism of some forms of utilitarianism ('work out the balance of happiness and unhappiness and select the option with the better balance of happiness') to focus instead on the character traits of the agent who performs the act. If Jones cheats in an exam to save the world from certain destruction, the virtue ethicist will ask "is Jones doing what a virtuous agent would do

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* Hooker calls this the 'spare wheel' objection[98].

in that situation?" or "what virtues -- for example, honesty, benevolence, justice -- is Jones exhibiting when acting in this way?".

As honesty is a virtue, the virtuous doctor would be strongly inclined to be truthful to his patients, judging rightly when telling the truth would be appropriate and doing so even in distressing or embarrassing circumstances.* In such situations, a doctor lacking the virtue may know that honesty is called for, but may be unable to bring himself to tell the truth (or may not even be aware that honesty is required). As Hursthouse notes, we would also expect an honest person to quickly correct misunderstandings which may be advantageous to him, not to pretend to know more (or less) than he does, to own up to something before waiting to see if others find out, to ensure that others understand any contract or agreement, and to say what 'everyone else fears to utter'[77](p.10-11).

Yet honesty entails more than merely speaking one's mind. One can be too frank or candid. Honesty must be tempered by other virtues. Lying to a terminally ill patient may exhibit the vice of dishonesty but also the virtue of kindness or compassion. How should these conflicting character traits be reconciled? The virtue theorist will point to the additional, intellectual virtue of *phronesis*, or practical wisdom, which will identify which moral virtue takes precedence over the other in the particular circumstances. When a doctor judges whether or not to tell the truth to a patient, phronesis will prevent him from simplistically viewing the case as a conflict between honesty and kindness, for honesty may, in fact, be the kind thing to do. Wise judgement will allow the virtuous doctor to discern the relationship between the two seemingly conflicting virtues.

Those who appeal to virtues can differ in their interpretation of their expression. Jennifer Jackson, establishing that truthfulness is a virtue due to its connection with trust and co-operation, argues that truthfulness 'requires that we repudiate lying altogether', although it may permit concealment, pretence and non-lying deception as these are not necessarily subversive of trust or incompatible with truthfulness'[6](p.131).

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* Honesty is a virtue because of its central role in human flourishing. Without honesty, Hursthouse writes, 'loving relationships', co-operation, knowledge acquisition and transmission of knowledge from generation to generation would be impossible[77](p.209-210).

Williams, however, argues that kindness can sometimes justify lying, as when 'nothing but pointless pain will follow if we tell the truth to the old lady about her daughter's illness or her son's disgrace', although he adds that it would be appropriate to feel regret at having lied[35](p.115). For Williams, the virtue of Sincerity 'enables the agent to think clearly and without self-deceit about the occasions when deceit is required'[35](p.121).

An appeal of virtue theory is its ability to explain why an agent might feel regret -- or moral residue -- even when performing what in the circumstances is the most favourable option. The virtuous doctor who justifiably lies to his patient should feel sadness at having been dishonest or, in Kantian terms, at having violated the 'humanity' or free rational choice, of the deceived. Virtue theory acknowledges the intuitively correct importance of an agent's motives and intentions (i.e., his inner state) in the moral evaluation of an act. According to virtue theory, an act, however objectively desirable, cannot be virtuous if lacking a certain inner quality. A person who ostentatiously gives to charity *solely* to impress a girl he is trying to woo will be less virtuous than a person who gives the money out of compassion for the less fortunate. Similarly, a doctor who, invoking the principles of beneficence and non-maleficence, lies to a patient only to avoid his own personal distress at breaking bad news cannot be said to be acting virtuously.

There is a certain indeterminacy about the very idea of a 'virtuous agent' and of virtues generally. Aristotle saw moral virtue as a 'golden mean' situated between two extremes representing the vice of excess, on the one side, and the vice of deficiency on the other[100]. The virtue of wittiness, for example, is sandwiched between the vices of buffoonery and boorishness. But the question remains: Where on the scale between buffoonery and boorishness is that golden mean? Aristotle explains and concedes that to attain the golden mean an agent must:

> [...] feel or act towards the right person to the right extent at the right time for the right reason in the right way -- that is not easy, and it is not everyone that can do it[100](p.109, 1109a25-b15)

The virtuous thing to do may be straightforward when faced with an easy decision, but less so when confronted with 'hard' moral decisions, such as those included in the

scenarios of the questionnaire used in the empirical research. The guidance provided by virtue ethics is thus less practical than the theoretically simple decision procedure of utilitarianism (greatest good for greatest number), or the easy-to-apply rigorism of Kant (don't lie). The virtues, like the four principles, need to be specified from their initial skeletal form ('exercise honesty, kindness, benevolence, compassion' and so on) to apply to the richness and complexity of the context in which they are employed.

A pluralistic compromise

Now the specification can and, to my mind, *should* contain a mixture of prima facie deontological rules and consequentialist considerations. Consequences alone are not enough for a satisfactory, action-guiding moral theory, nor are inviolable moral rules, nor are bare virtues. What is needed is a compatible amalgam of elements stemming from each normative theory, rather than a rigid adherence to a single fundamental ethical system. Since each self-standing theory contains appealing aspects as well as undesirable ones, we should strive to combine the positive elements of each while reducing the shortcomings to a minimum.

The different theories can complement each other, at least up to a point. Take virtue theory and principlism: a virtuous agent, for example, is more likely to properly apply the four principles than a less virtuous agent. The principles provide a guideline for right action, but nevertheless require specification and ordering based on the individual circumstances. There is no predetermined lexical ordering of the principles or rules, as is the case for some deontologists[101]. This delicate transition from the abstract to the concrete, from the general to the specific, is more likely to yield morally desirable results if performed by a virtuous agent. So, the virtue of benevolence can drive the proper application of the principle of beneficence and the same goes for other virtues and principles.

Virtue theory can also help explain why many people feel a natural aversion to lying by pointing to the attitudes, intentions and character traits that are often associated with lying. As Isenberg writes, lying exhibits a "character that is probably *symptomatic* of further disvalue and of moral delinquency"[102](p.479) (his emphasis). Kupfer also identifies two contingent harms to lying which affect not the target, but

the liar himself. These are 1) disrespect for other people, and 2) the threat to the integration of one's personality, by 'misrepresenting who and what we are'[64](p.103 and p.120). So although we need not agree that lies possess intrinsic disvalue, we can agree that lying *tends* to indicate a deficiency of virtues.*

The main difficulty lies in deciding how much weight each element from the various ethical systems should be given as a proportion of the total theory. What is likely is that the priority between the various elements will not be fixed, but dependent on the context. This difficulty is, in my view, an advantage of a pluralist theory since it reflects the actual difficulty of moral deliberation. It is thus a moderate form of moral particularism. Jonathan Dancy defines extreme moral particularism as:

> [...] the claim that there are no defensible moral principles, that moral thought does not consist in the application of moral principles to cases, and that the morally perfect person should not be conceived as the person of principle[103].

An extreme moral particularist does not rely on principles to make moral judgements but on a perceptual capacity to recognize the morally salient features of a case, features whose moral relevance are dependent on context.† Hence in some contexts, such as in a game involving deception, the fact that an action is a lie may be a *positive* reason to do it[104](p.268).

A *moderate* moral particularism, then, would combine general principles with an evaluation of right action based on 'local' considerations. Moral principles are not, in themselves, sufficient to determine right action but are dependent on particular factors. On this view, the valence of an act-type, such as lying, remains constant in *all* circumstances but the final duty, all things considered, may require lying to promote a weightier moral good. This is in contrast to extreme particularism, which would claim that the polarity of lying can be reversed in some contexts.‡

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* Kupfer's own position is that although lies possess inherent disvalue, lying can nonetheless be justified (see p.45 of this thesis). Their inherent disvalue stems from the immediate restriction of the deceived's freedom and the internal conflict involved in lying[64](p.103). This last inherent disvalue echoes Augustine's observation in the *Enchiridion* that a liar has 'one thought in his heart and another on his lips'[52](chapter 18).

† The context-dependency of reasons is referred to as 'holism'[104](p.267).

‡ In *Moral Particularism*, Brad Hooker offers a rebuttal of the moral particularist's critique of generalists[105]. Invoking cases where harming others is morally justifiable, as in justified punishment, in self-defence, or in defence of others, Hooker says the generalist can either claim that 1) violating the principle of non-maleficence, though justified, has negative valence ('a pro tanto moral minus [...]

Based on the above, a Rossian intuitionist approach appears most plausible. This form of intuitionism would espouse ethical pluralism by accepting the existence of a plurality of moral principles irreducible to one fundamental principle (as in utilitarianism or Kantianism). The theory could accommodate various rules, duties and principles from the theories mentioned earlier. Furthermore, it would accept that the principles are prima facie. In other words, they would be binding unless trumped by a weightier prima facie moral principle. This would not annul the initial weight of the overridden principle, but would provide a sufficient reason to choose one course of action over the other. As Audi writes, Ross believed prima facie duties were '*ineradicable but overridable*'[106](p.24) (his emphasis). The ineradicable nature of prima facie principles would explain the importance of justification and eventual apology in decisions to deceive patients, even if deemed morally right. Finally, the prima facie nature of the principles would require consideration of case-specific details and, consequently, a context-sensitive evaluation of right action.

The absence of a single scale with which to measure right and wrong (unlike utilitarianism, for instance) raises a problem for the pluralist theory described above. How can we balance a prima facie deontological consideration with a prima facie utilitarian consideration? Without a scale, the two relevant elements may be incommensurable and deriving a final duty may thus be impossible. In reply to this objection, one could point to situations where two considerations clash without presenting a problem to our moral evaluation of final duty. Imagine a scenario where you must break a promise to go to the pub with a friend in order to bring an injured child to A&E. Intuitively, we feel breaking the promise is justified in the circumstances, despite the different grounds of the competing obligations. There must be a covering value against which we judge the moral desirability of various options. I thus tend to side with Audi's view:

> If there is incommensurability, in the sense of the absence of a common measure for all moral considerations, there can nonetheless be *comparability* in the sense implying the possibility of a rational assessment in the context of the relevant facts[106](p.65).

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outweighed by opposing moral pluses') or that 2) the principle can be specified to include right-making exception clauses (e.g., do not harm others except in cases of self-defence, etc.)[105](p.10-11).

Ruth Chang also argues that an inability to measure scalar differences in value between options does not preclude comparability[107](p.31-33). Differences can be deliberated in a qualitative sense. Chang also believes in the possibility of comparability within value pluralism, claiming that seemingly disparate entities or actions can be compared in some respects. Hence, Mozart and Michelangelo can be compared in terms of some value, such as creativity.

Of course, comparability does not resolve the problem of final duty. There may be situations where comparing the weights of prima facie duties does not lead to a clear resolution. In such cases, where obligations are equally weighty, the agent is faced with a moral dilemma.

As moral pluralism must address the theoretical issue of moral dilemmas and as dilemmas are so central to discussions of truth-telling in medicine, it is worth dwelling on both the concept of a moral dilemma and its implications to the present study.

Moral dilemmas

The phrases 'moral dilemma' and 'moral problem' are often used interchangeably in everyday parlance. Nevertheless, the two are not synonymous in the philosophical literature.* Although a moral dilemma is invariably a moral problem, a moral problem is not necessarily a moral dilemma. Whereas many moral problems can be solved, a (genuine) moral dilemma is generally considered to be irresolvable.

A moral dilemma occurs when an agent is morally required to perform two (or more) actions but cannot do one without failing to do the other(s). Gowans defines a moral dilemma as a 'situation in which an agent *S* morally ought to do *A* and morally ought to do *B* but cannot do both, either because *B* is just not-doing-*A* or because some contingent feature of the world prevents doing both'[108](p.3). The result is that

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* There is a further distinction between a moral dilemma and a moral disagreement. Whereas a moral dilemma is an inner conflict, a moral disagreement typically refers to a moral conflict between two or more persons.

whatever action the agent chooses to do, he will have committed a moral wrong by failing to perform the other.

Moral dilemmas can be divided into two main types: *epistemic* and *ontological.* In the epistemic type, the agent simply does not know which of the moral requirements takes precedence over the others, even though one requirement may be stronger than the rest. Although the agent *ought* to do A, his intense desire to do B (and not A) creates the semblance of a moral dilemma. Still, the right action is to do A. In the ontological type, not only does the agent not know but the moral obligations possess equal weight or priority (i.e., they are equipollent). Genuine moral dilemmas (if, indeed, there are such things) are ontological[109].

Some philosophers (notably both Kant and Mill) do not believe that genuine moral dilemmas exist[110](p.39)[111](p.55). Mill writes:

> If utility is the ultimate source of moral obligations, utility may be invoked to decide between them [conflicting rights and duties] when their demands are incompatible[111](p.55).

A consequentialist faced with a situation where all the acts would result in the same amount of utility might simply recommend the agent to choose at random. The agent is not confronted with an irresolvable moral conflict but a choice. Even some deontologists, who would criticise consequentialists for limiting their concern to consequences and ignoring the nature of the acts themselves, may refuse to accept the existence of (genuine) moral dilemmas. Absolutist deontologists, who believe there are well-ordered, exception-less moral rules, would certainly question the possibility of moral dilemmas. A truly Kantian moral theory which could simultaneously require the agent to do *A* and also require him to do *B* when both cannot be done concurrently would be logically deficient since moral duties, for Kant, are binding. In the *Grounding for the Metaphysics of Morals*, Kant emphasizes that the Categorical Imperative is 'limited by no condition, and can quite properly be called a command since it is absolutely, though practically, necessary'[48](p.26). As a result, Kant explicitly states that 'a conflict of duties and obligations is inconceivable'[110](p.39).

Virtue theory, on the other hand, can accommodate moral dilemmas. It is possible for two truly virtuous agents to act differently in a situation (situation X) where there are

no moral grounds for choosing action A over action B. In short, to the question "what would a virtuous agent characteristically do in situation X?" the answer could be "either A or B". Indeed, Hursthouse laments the fact that discussions of difficult moral conflicts often fail to acknowledge the possibility of genuine moral dilemmas. She writes that many people commenting on 'hard' ethics cases

> [...] rarely even entertain the possibility that the dilemma they are discussing is irresolvable; on the contrary, they assume that there must be one, correct, decision to be made about it which it is the business of their moral theory -- usually utilitarianism or deontology -- to reveal or discover[77](p.44).

In the pluralist moral theory that I espouse, moral dilemmas are also possible. It is conceivable for an agent to encounter a situation where he is faced with several options which are supported by different but *equally strong* prima facie moral reasons pointing in opposing directions. The validity of consequentialist and deontological considerations coupled with the absence of a hierarchical or lexical ordering of moral rules opens up the possibility of genuine moral dilemmas. Like comparing apples with oranges, comparing a deontological rule against lying with a consequentialist rule to prevent harm, for example, may be extremely difficult to do. Attributing a moral weight to the respective rules will be dependent on the context, the degree of harm prevented, the seriousness of the lie, the intentions of the liar, and, to some degree at least, to the evaluator's intuition. It is by no means an exact science. Moral dilemmas may stem from the relative incomparability of these radically different types of rules.

This last thought is held by Thomas Nagel, who believes that moral dilemmas arise because it is impossible to compare different types of moral values[112]. 'An even balance requires comparable quantities' writes Nagel[112](p.175). Hence, for Nagel, talk of balancing moral weights is inaccurate as it seems to validate comparisons between incomparable types. In the face of incomparable quantities, the moral agent is faced with a decision that relies not on rational deliberation but on good moral judgement (see the next section). As I explored earlier, Audi and Chang would disagree with Nagel's views on the incomparability of moral values, claiming that even disparate moral values can be rationally compared in some respects[106](p.65) [107](p.31-33).

Some might criticise pluralist theories for allowing such dilemmas to arise and for failing to provide action-guiding rules applicable to all situations. Nevertheless, a moral theory which admits the possibility of moral dilemmas better reflects the reality of moral life than one which does not.* After all, every moral agent will have experienced what he believes to be a moral dilemma at some stage in his life. Now, one way around this is to say that these are not 'true' moral dilemmas but merely epistemic ones resulting from inadequate factual knowledge, lack of reason (or practical wisdom) or ignorance. It is difficult to argue against such a position, as the opposition could always claim that even though the problem might *appear* to be irresolvable and even though it might appear that even hundreds of wise, reasonable decisions-makers are knowledgeable and fully informed, they are not quite wise, reasonable, knowledgeable and informed enough to perceive the elusive but objectively correct answer. The upshot of this irrefutable, unverifiable claim is summed up by Mary Mothershill:

> I think we must conclude that although it is possible that all dilemmas are merely apparent, it is also possible that some dilemmas are genuine. This is not a very interesting outcome[114](p.76).

On reflection, the implications of the debate on moral dilemmas to truth-telling in medicine are limited. If genuine moral dilemmas exist, then it is foolish to lay blame on the moral agents faced with the problem (assuming the dilemmatic situation arose through no fault of their own). The dilemmas could be regarded as the inevitable result of an area of medicine where occasionally moral precepts of equal normative weight or incomparable value conflict with one another. The moral agents who find themselves in that situation should be morally supported rather than castigated.

If, however, there are no moral dilemmas, then the implicated moral agents could theoretically be blamed for choosing the wrong course of action. In most cases where deceiving a patient is an option, the doctor is *not* faced with a highly complex, possibly insoluble situation. Most of the time there *is* a right or wrong answer, irrespective of one's position on the existence of genuine moral dilemmas. Stronger

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* Bernard Williams doubts the validity of the agglomeration principle (i.e., I ought to do A and I ought to do B, therefore I ought to do A and B), which is sometimes invoked to refute the existence of genuine dilemmas, partly because rejecting it provides 'a more realistic picture of moral thought'[113](p.132).

reasons can be given for one action than for others. But, if there are no true moral dilemmas, what should we make of those cases where opinion is divided and what *seem* to be equally strong reasons can be offered for mutually exclusive courses of action? In the absence of agreement and apparently decisive reasons for any position, it is unclear who the arbiter of praise or blame should be. How would we know for certain that the chosen option was the 'right' or 'wrong' one? Even if we could legitimately blame the decision-maker, the extremely difficult moral choice would lessen the strength of the blame. *Ceteris paribus*, an agent who makes a wrong decision in a hard case of moral conflict is less blameworthy than one who makes a wrong decision in a case where the ethically desirable option is clear.

An objectively right answer on the best course of action might, for some, be theoretically and logically necessary but it is practically useless if informed, reasonable agents cannot derive the answer from their moral code. The remark "there is a right answer but no one knows what it is or why it's right" would be unhelpful. It might even be harmful, as it could lead to delays in decision-making and to undue levels of regret on the part of moral agents. On the practical level, then, there seems to be little difference between accepting or rejecting the reality of true moral dilemmas. In 'hard' moral cases, the relevance of the distinction is of no more than theoretical interest.

For my purposes, I shall continue to use the phrase 'genuine' dilemma to refer to the definition of a moral dilemma given at the beginning of the section and -- to acknowledge the possibility that there are no true moral dilemmas -- to cases which I term pragmatically irresolvable (i.e., cases that may have a right answer in theory but whose answer cannot be ascertained clearly at the time by a reasonable, adequately informed moral agent).

The mystery of moral judgements

By moral judgement, I refer not to the product of deliberation but to a moral virtue sometimes called 'moral wisdom' or 'moral discernment'[115]. What do we mean when we say that, in the face of moral conflict, an agent should exercise his 'moral judgement'?

In practice, how people exercise moral judgement is not entirely understood. Reason and emotion are two key ingredients in moral judgement, but their interaction is unclear. Advances in cognitive neuroscience suggest that reasoning plays only a restricted, though significant, role. Greene and Haidt, two North American psychologists, claim that 'automatic emotional processes tend to dominate' and Greene *et al.* have demonstrated that brain areas linked to emotion were more active in personal moral dilemmas than in impersonal and non-moral dilemmas (e.g., keeping money found in a lost wallet and choosing between train or bus travel, respectively)[116](p.517)[117]. These emotions influence moral judgement but are not necessarily determinative. They can, it seems, be overcome by reasons.

Although excessively strong emotions can distort moral judgement so too can a deficit of emotions. Sydney Callahan laments the fact that 'in philosophical arguments the problem of such deficits is regularly ignored and that of excessive emotion emphasized'[118](p.29). For Callahan, emotions are warning flags that encourage reflection to understand why we feel, say, an aversion to torture. Emotions can also trigger a reassessment of previously accepted moral principles and ultimately lead to changes more in tune with reason and emotion. Alluding to the method of reflective equilibrium, Callahan writes 'new ideas, arguments, or emotions should be continually checked and mutually adjusted'[118](p. 32). This coherence method serves as an epistemic 'check'.

Philosophers have tended to use non-specific language when referring to moral judgement. Kant viewed judgement as the 'faculty [...] of determining whether something stands under a given rule'[119](p.177). Judgement itself, however, is not rule-governed and is defined as a 'special talent that cannot be taught but only practised'[120](p.268). Discussing the doctrine of the mean, Aristotle considered moral judgement about the mean as a 'perception'[100](1109b15-26, p.110).

In the last century, Ross adopted Aristotle's view of moral judgement as 'perception'[79]. There is a degree of interpretation required in applying prima facie duties. We must decide whether or not a particular duty applies in a situation and, if so, what action should be taken to fulfil this duty without violating a stronger,

countervailing duty. Ross claimed that no rules existed to estimate the relative stringency of conflicting prima facie duties:

> This *sense* of our particular duty in particular circumstances, preceded and informed by the fullest reflection we can bestow on the act in all its bearings, is highly fallible, but it is the only guide we have to our duty[79](p.42) (emphasis added).

More recently, moral particularists such as Dancy have attributed great importance to the idea of grasping the moral landscape by 'discernment'. Whereas most principlists would claim that moral judgement should supplement necessarily indeterminate principles to specify action, Dancy believes that moral judgement can replace principles entirely:

> There is nothing that one brings to the new situation other than a contentless ability to discern what matters where it matters, an ability whose presence in us is explained by our having undergone a successful moral education[121](p.50).

Responding to criticisms that the process of balancing the weights of prima facie duties is too intuitive, Beauchamp and Childress offer conditions that, if met, would justify infringing a prima facie moral norm[72](p.19-20). These include the need for better reasons to override the norm than not to do so, the realistic nature of the objective, the lack of morally preferable alternatives, the minimization of the negative effects of infringement, and impartiality. These conditions stress the importance of reflection and deliberation in exercising judgement and counter the emotivist belief that moral judgements are no more than 'disguised imperatives'[122](p.10). Morally acceptable judgements must therefore be supported by good reasons which satisfy a set of conditions and which are based on relevant and accurate facts (hence the need for good empirical research). Although moral judgement, through informed, reasoned, context-sensitive, critical analysis, can resolve most moral conflicts, it is not a moral panacea. As Larmore writes, 'in many cases [...] judgment will be powerless to settle the [moral] conflict.'[123](p.11). An appeal to reasons and arguments will not always yield a solution to moral dilemmas.

Arguing against the arbitrariness of moral judgement, Larmore continues:

> We should realize not only that there are limits to *theoretical* understanding, but also that there are other kinds of understanding that are more appropriate for grasping the nature of moral judgment[123](p.21) (his emphasis).

Both Callahan and Larmore highlight the limitations of theory in elucidating the nature of moral judgement. Equating moral judgement with the balancing of norms or the systematic application of moral rules to individual situations is ignoring the emotional and individual aspects of moral deliberation. Charles Taylor alludes to this when he claims that resources for resolving conflicts 'lie partly in our sense of our lives as a whole, the lives we are leading'[124](p.183). Beyond its rational aspects, there is something mysterious and deeply personal about moral judgement, akin to a moral 'sixth sense' acquired gradually throughout an agent's life. This is not, in my view, a disappointing conclusion. Aside from reflecting the reality of moral psychology, it encourages the moral agent to expand his emotional, cultural and intellectual horizons (Larmore recommends reading 'the great works of imaginative literature') to improve his moral judgements through a more reflective, insightful understanding of his self and of others. Good moral judgement will reduce the likelihood of making wrong decisions, revealing apparent dilemmas as merely epistemic ones. But even then, Nagel notes, there are moral dilemmas so complex that 'judgment cannot operate confidently'[112](p.180). Even the wisest of the wise will hesitate in the face of a moral dilemma.

The Publicity Condition

Rawls, Bok and Gert each invoke the centrality of the *publicity condition* (PC) to the justification of a moral theory or rule[9 95 125]. The PC requires a moral rule to be subject to -- and withstand -- criticism from a public made up of 'reasonable' persons, thereby reducing the chance of perspectival bias, allowing relevant parties to become involved in the deliberative process, and providing insight into the moral reasoning pertaining to the decision[9](p.90-106).

Although usually applied to rules or principles, the PC could also be applied to individual judgements about conflicting moral claims. To apply the test to specific acts of lying, Bok writes:

> We must formulate the excuses and the moral arguments used to defend the lies and ask how they would stand up under the public scrutiny of [...] reasonable persons[9](p.93).

Applied to individual cases of deception, the PC will not be as useful as when it is applied to an entire practice (e.g., doctors deceiving very sick patients) since the decision-maker will be relying on hypothetical reasonable persons or possibly the advice of friends or colleagues. Imagined reasonable persons and peers are not impartial. With practices, however, a higher level of justification can be gained by opening up the consultation to everyone, including the deceived. The moral legitimacy of deceptive policies could then be publicly discussed in the press, at public meetings, or in educational institutions[9](p.99). This present thesis, by reflecting the actual views and reasoning of doctors, patients and members of the public -- and thus acknowledging the perspectives of the potential deceivers and the potentially deceived -- aims to go some way towards satisfying this important publicity criterion.

But what of reasoned disagreement between reasonable persons? How should the publicity condition deal with this? Gert draws a distinction between weakly and strongly justified violations of a moral rule:

> Strongly justified violations are those all impartial rational persons would publicly allow; weakly justified violations are those on which impartial rational persons can disagree[125](p.151).

With regards to deception, I have argued that there may be situations where the reasons for and against deception are equally persuasive. Impartial rational persons may disagree, differing, as Gert notes, on their ranking of the goods and evils or on the likely consequences of the public knowing about the permissible violation of the moral rule[125](p.238). In such cases, the violation of the moral rule would be *weakly* justified. It is probable that most of the 'difficult' cases involving benignly intended deception in medicine will be weakly justified.

However valuable in reducing bias and sharpening moral reasoning, the publicity condition is of limited use in 'moral quandaries which have no good answer given our limited information, powers of reasoning, and foreknowledge'[9](p.101). The publicity condition may also be unhelpful in cases of moral dilemmas, when reasonable persons disagree (genuine moral disagreements), or when immediate action is needed.

What the publicity condition reveals in such difficult cases is that appeals to substantive morality may not be fruitful and that it may be preferable to adopt a *procedural* approach to resolve differences between reasonable people. The next step would then be to arrive at a set of morally acceptable decision procedures. In Western societies, for example, major disagreements between parties are sometimes referred to a court of law, where judges resolve otherwise intractable disputes. But what constitutes a fair procedure?

Leventhal lists six rules to determine the fairness of a procedure[126]. A fair procedure should 1. be applied consistently (across time and persons), 2. be conducted without personal bias or self-interest, 3. be based on accurate information, 4. be correctable in case of mistakes or a change of mind, 5. reflect the values and concerns of those affected by the decision and 6. be compatible with fundamental ethical standards. Although Leventhal is concerned with the fairness of allocation procedures, Myyry and Helkama believe that the same rules can be applied more broadly to moral decision-making[127]. Parker, in his account of the characteristics of what he terms 'formal deliberative ethics', emphasizes the importance of arriving at a set of decision-making procedures compatible with the principles of respect for persons and the requirements of the publicity condition[128].*

In our particular case, one such decision procedure would be to ask patients early on in their contact with doctors, perhaps using an 'ethics history sheet', how much they would like to be told about current, suspected, or future illnesses and whether they would like relatives to be informed about their condition and involved in decision-making, and then to control information-giving based on those answers[129]. This idea is raised specifically in the empirical part of the research and discussed in chapter 10.

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* I examine the notion of 'respect for persons' on p.90-92.

Conclusion

On the issue of lying and deception, two types of tension emerge amongst moral philosophers. The first is between absolutist and non-absolutist positions on the acceptability of lying. I argued, however, that even hard-nosed absolutists possess ways to justify exceptions to the absolute prohibitions against lying or that, at the very least, they accept that lies fall within a broad spectrum of moral badness, from easily pardonable to deserving of death. I have also attempted to show that Kant's Formula of Universal Law and his Formula of Humanity can be interpreted in such a way as to allow deceiving other rational agents if sufficiently specified and performed with the right intentions. Furthermore, I suggested that Kant may himself have conceded that lying, in extreme circumstances, could be justifiable.

The second tension rests on the relative weight that should be given to non-absolutist obligations. If the duty to refrain from deception is not absolute, in what circumstances can it be breached? I examined straightforward and more sophisticated forms of utilitarianism, rights-based theories, contractualism, as well as virtue theoretical interpretations on the ethics of deception and concluded that, although each contained appealing elements, none plausibly encapsulated all the moral dimensions of deception. As a result, I favoured a pluralist, intuitionist theory, containing a flexible mixture of deontological, consequentialist, and virtue theoretical elements, whose priorities would be dependent on the particularities of the situation at hand and on the exercise of moral judgement.

In the final part of the chapter, I examined some of the controversies regarding the nature of moral dilemmas and suggested that these theoretical debates are of limited relevance to my study. I also presented accounts of the nebulous notion of moral judgement, before assessing the strengths and limitations of the publicity condition.

In the next chapter, I focus on truth-telling and deception in medicine and medical ethics, surveying various arguments for and against deceptive practices in the doctor-patient relationship and examining the relationship between trust, truth and truthfulness.

CHAPTER 4

Truth-Telling and Deception in Medicine and Medical Ethics

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'[130](p.34). In 1961, Oken solemnly opened his seminal article on doctors' attitudes to cancer disclosure with the words 'No problem is more vexing than the decision about what to tell the cancer patient'[8](p.1120). Bok wrote of a 'turmoil in the medical profession regarding truth-telling'[9](p.226). More recently, Jackson claimed that 'it is generally recognised that there is much to discuss regarding when intentional deception may be justified'[10](p.183).

Despite the widely acknowledged need to examine the ethical issues surrounding truth-telling and deception in medicine, codes of medical ethics have long avoided taking a stand on doctors' obligations of veracity. The American Medical Association (AMA), in its Principles of Medical Ethics, was silent on the matter until 1980, when it added a clause stating only that doctors should 'deal honestly with patients and colleagues'[12]. In its 2001 amendment, the AMA modified the passage to

> A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities[131].

The World Medical Association's International Code of Medical Ethics also enjoins doctors to 'deal honestly with patients and colleagues', while the General Medical Council instructs doctors to be 'honest and trustworthy'[13 132]. The codes, in short, tend to deal with the issues of truth-telling and deception in a minimalist and absolutist way.

In the conclusion of their study on doctors' use of deception for patients, Novack *et al.* ask 'How could codes of medical ethics more explicitly address the physician's

obligation to be truthful and more clearly define which moral imperatives take precedence in situations of conflict?'[22](p.2985). Da Silva *et al.* have called for the Brazilian Medical Ethics Code, which obliges doctors to reveal important information regarding treatment except when the truth may harm the patient, to establish 'clear normative elements aiming to better define the circumstances under which the physician would be authorised to omit the truth'[133](p.423).

In 2004, the British Medical Association (BMA) discussed the issue of truth-telling in some detail in a revised, voluminous edition of their book 'Medical Ethics Today', aimed to provide guidance for doctors[134]. Various sections explore the subject of truth-telling. One section asserts:

> Part of the doctor's role is to ensure that decision making is returned as much as possible to the patient, rather than pre-empting the choice by withholding potentially important information[134](p.36).

The underlying reason for this statement is that imparting important information is integral to enhancing the autonomy of the patient. The problem is that this forms only 'part of the doctor's role' -- what happens when this part conflicts with another? The book addresses this in the section on dying patients, where it reiterates the importance of providing sufficient information to the patient but this time introduces countervailing considerations:

> At the same time, it is important not to impose unwanted information in a way that could have the effect of removing a valuable coping strategy for the patient and could cause great harm. There are no easy answers to this dilemma [...] Pressure to prevaricate should be resisted, but at the same time it must be recognised that individuals require varying degrees of time and support to assimilate what they are told[134](p.371).

What if the doctor is unsure whether the information is wanted or unwanted? A re-reading of the passage reveals some confusion. One dilemma mentioned in the extract refers to a different problem from the one presented. The main dilemma, surely, is between:

A: providing as much information as the patient wants or needs to make a decision, and

B: not providing information if this could adversely affect the patient's coping strategy or cause great harm

A may at times conflict with **B**, thus creating a dilemma where choosing one violates the other. The authors of the handbook have however added an epithet ('unwanted') in **B** and combined it with the negatively laden verb 'to impose'. There is no conflict between **A** and the BMA's **B***: not imposing unwanted information if this could affect the patient's coping strategy or cause great harm.

In a roundabout and rather reluctant way, the passage appears to condone or permit prevarication in situations where patients have not had 'time and support to assimilate' the information already given and when the new disclosure could result in great harm.

Truth-telling and deception 'at the coal face'

Although honesty is hailed as necessary in many codes of ethics, it is not always upheld in practice[13 14]. Miyaji, in a study on truth-telling among American doctors caring for terminally ill patients, showed that many doctors mirror this emphasis on honesty, but only superficially[15]. When asked whether or not they informed patients of a terminal illness, the doctors interviewed generally gave 'textbook' answers stressing the importance of honesty and truth-telling. Yet when probed further, their accounts revealed numerous ways in which they controlled the disclosure of information. For instance, many doctors did not provide information unless specifically asked for it by the patient, especially if the information concerned an unfavourable prognosis. At times, doctors used euphemisms or ambiguous phraseology to soften bad news or to evade stating what they perceived was undesirable information.

When doctors did provide information, they were generally much more inclined to discuss details of possible treatments than information on prognosis. When they

decided to disclose details of the prognosis, many doctors gave deliberately optimistic estimations. One senior internist commented:

> I wouldn't tell an old mother, or a child, and if the person is, in my opinion, likely to take it badly, I will delay telling them until they gradually begin to learn the truth. A lot of them, for example, will go out and read a book and the book will say, 'this is always fatal', then they'll come back and say 'hey, what about that?' and I'll say, 'well, that book was written 10 years ago and it isn't always fatal.' As a matter of fact, none of these diseases is always fatal, but *they'll soon realize what the game is.* As I say, I can usually tell, because they stop asking questions[15](p.257) (emphasis added).

A number of interesting points are raised in this extract. Firstly, the interviewee highlights the *gradual* process of truth-telling. It is not necessarily a one-off event, where the whole truth, in all its horror, is 'dumped' on the unsuspecting patient. Secondly, it stresses the active role of the patient in finding out what is wrong and the gravity of the situation. In this passage, the interviewee mentions books as possible sources of knowledge. Thirdly, the interviewee seems to believe that he is not deceiving the patients. Refuting the truth of the prognosis in the book, he says 'As a matter of fact, none of these diseases is always fatal'. The possibility of deception is removed by appealing to the fact that, strictly speaking, no disease is *always* fatal. As I argued in chapter 2, however, the truth-value of an utterance does not in itself indicate whether the utterance is deception. In this context, it appears that the doctor believes the patient will die from the disease in question but attempts to conceal this fact by asserting that the medical textbook is factually incorrect and, through a conversational implicature, implies that the patient has a better chance than he actually has.

The final point relates to the interviewee's use of the word 'game' to refer to the doctor-patient interaction. There is an interplay between doctor and patient, whereby each tries, in a roundabout way, to uncover what the other party really thinks. As the direct truth is seemingly taboo -- and as lies are also seemingly 'against the rules' -- both parties interpret responses in light of the unspoken rules to find out what the other party really thinks. This is reminiscent of what Glaser and Strauss called the 'ritual drama of mutual pretense', where doctors and nurses in the 1960s used various tactics to hide news of the patient's impending death while the patient would use

strategies to uncover the truth about his situation[135]. For Miyaji, many doctors view disclosure not as a straightforward imparting of information, but as a process of translation[15].

Disclosure as translation

The idea of disclosure as a 'translation' is an appealing one, since it highlights the idiosyncratic aspect of disclosure (every translation differs in some way from the next) as well as pointing out the ease with which the original can be adapted to fit the objectives of the translator. The original (i.e., what is in the doctor's head) and the translation (i.e., what is disclosed) will bear some resemblance to each other, but the extent of the similarity will depend on the inclination of the translator. No doubt some doctors will want their translation to be as faithful to the original as possible, while others will sacrifice detail for the comfort of the reader. The Italian proverb 'traduttore traditore' -- 'to translate is to betray' -- in our context adopts a double meaning. The translation can betray both the original, robbing it of its initial meaning, but also the reader, who can be led to believe something that is far removed from the original. It is thus both a linguistic and an interpersonal betrayal. It may in fact be more accurate to add a third meaning, as the translation may constitute an intra-personal betrayal, in the sense of self-deception, whereby the translator wrongly but genuinely believes that his translation accurately reflects the original.

Unfaithful translations: economies with the truth and euphemistic language

In the very first issue of The Lancet, an anonymous author summarized a lecture by the 'distinguished professor' Sir Astley Cooper. The author claimed that Sir Astley:

> [...] cautioned the pupils from speaking unguardedly before the patients; it could do no good to let them know what was intended for their cure, but very often prevented it[136].

The eminence of Sir Astley and, if we are to believe the narrator, the thunderous applause at the end of his lecture provide good evidence that shielding the truth about the nature of treatment to patients was certainly not frowned upon and possibly encouraged at the time. Sir Astley's advice to his students is repeated several decades later by an even more eminent figure in the history of modern medicine, Sir William

Osler. He would sometimes tell an angina patient that he had 'neuralgia of the pneumo-gastric nerve' to alleviate an anxiety that was likely to aggravate the condition[7](p.265). Osler also told medical students to avoid saying anything which nearby patients might find stressful[7](p.265). Even today, a popular medical textbook for medical students encourages students to avoid using terms like 'cancer', 'motor neurone disease' and 'multiple sclerosis' when talking to patients, but instead to use terms that are less likely to alarm patients (and less likely to be understood by them) such as 'neoplastic disease', 'anterior horn cell disease', and 'demyelinating disease'[137](p.xiii). Miyaji revealed that many doctors follow the advice of the student textbook[15]. The doctors replaced so called 'dirty' words, such as 'malignancy' and 'cancer', with less threatening terms and euphemisms.

The authors of the medical textbook mentioned above, surprisingly, do not provide any reasons for this substitution of terms (or 'translation')[137]. Presumably, the main reason behind such linguistic manoeuvres is to avoid uttering words loaded with negative, frightening and often inaccurate connotations. As Sontag has shown, medical terms such as 'cancer' and 'tuberculosis' have been heavily metaphorized, affecting the very experience of illness by creating undesirable associations[138]. Sontag's *Illness as Metaphor* thus yearns for the liberation of distorting and damaging metaphors from everyday discourse[138].

One major problem with a term such as 'cancer' and its metaphors is that they refer to *all* types of cancer, when in fact many subdivisions exist within the category 'cancer', each with radically different treatments and prognoses. A benign, easily treatable form of cancer is placed in the same linguistic basket as a malignant, fatal cancer, potentially causing misplaced fear and confusion among some laypersons. This does not mean that the word 'cancer' should be eliminated from the English language altogether, but that doctors should be encouraged to explain this wide variation to their patients.

The following story, recounted in a letter to *The Lancet* by the physician Thurstan Brewin, illustrates how patients and doctors may hold different interpretations of the word 'cancer'. Brewin tells the story of a 90-year-old patient, once decorated for courage in battle and terrified of developing cancer[16]. A biopsy of an ulcer on his lip

revealed a benign form of cancer that would need only a short course of radiotherapy. The patient asked him directly whether he had cancer. Brewin, 'emphatically, without the slightest hesitation or qualification' told him that it was not cancer. He goes on to justify his lie by stating that 'he had what the medical profession calls cancer. He did not have what he [the patient] meant by cancer. He did not have a shameful, painful, fatal disease that would soon spread'. Brewin's justification fits in well with the idea mentioned earlier of information giving as a process of translation. 'Cancer', as used and understood in the medical literature does not translate into 'cancer' in the patient's idiolect (i.e., his own linguistic system). The table below compares what Brewin believes to be the likely features of 'cancer' in the patient's idiolect with the medical profession's understanding of the term (in the context of the patient's condition). Each feature has binary values ('+' or '-') which indicate the presence or absence of the feature, hence [+ fatal] means that fatality is a feature of cancer.

Cancer (patient)	**Cancer** (medical profession)
+ disease	+ disease
+ shameful	- shameful
+ painful	- painful
+ fatal	- fatal
+ fast spreading	- fast spreading
- treatable	+ treatable

Table 1: two different interpretations of the properties of 'cancer'

From the table above, Brewin might argue that a simplistic translation would not only be a false translation because inaccurate but positively harmful. It would be possible, then, to say that Brewin did *not* lie, as the patient did not have what the patient understood as cancer. If aware of the considerable discrepancy between the respective interpretations of the term 'cancer', telling him he had cancer would have been more deceptive -- perhaps even more of a lie -- than telling him that he did not have cancer!

Brewin can thus attempt to justify his 'deception' in two ways. The first is to deny that he deceived his patient at all. The second is to say that, even if he *did* violate a

principle of veracity, it was outweighed by the demands of the principle of non-maleficence which, in this instance, justified 'benevolent deception' to protect the patient from avoidable harm.

How did Brewin know what his patient meant or understood by cancer? Most people fear cancer, and many people are indeed terrified by the prospect of developing the disease, but this alone is not enough to justify shielding them from the truth. That the patient was decorated for courage could be as much a reason to disclose as a reason to withhold the term 'cancer'. Neither should the patient's advanced age be a factor. In answer to the question 'Do you think there is anything shameful in having cancer?', a 1940 opinion poll in America showed that 98% said no[139]. Similar results were found in a poll 10 years later[139](p.217). This case could easily be an example of a doctor making unjustified assumptions about his patient's beliefs.

As mentioned earlier, Brewin makes a clear distinction between what he, a medical professional, understands by 'cancer' and what the patient supposedly understands by the term. On the basis of this discrepancy, he opts to withhold the information to avoid misunderstanding. This rationale may be appropriate in some cases, but in others it could lead to harmful paternalism and unnecessary violations of patient autonomy. This benevolently paternalistic philosophy, which requires good faith and sound judgement, can be inappropriately used or used with wrong motives, such as to avoid an awkward disclosure. That it can be abused does not entail that it should be scrapped altogether, but it does indicate that it should be used with great caution and with ample evidence that it is appropriate in the circumstances. It also raises the problem of reliably predicting patients' reactions to disclosure. There is a danger that doctors will make evaluative decisions affecting individuals based on generalisations, which may themselves be empirically dubious. My critique of Brewin is primarily epistemic, relating to what he could have reasonably claimed to know about his patient.

Brewin appears unconvinced that his patient might have been swayed by reassurances and rational argument, and hence considers withholding the information as a legitimate means to avoid an anticipated panic. This approach could more easily be defended if the patient clearly lacked the autonomous ability to make a rational choice,

but whether this was so in this case is a moot point. In his defence, Brewin could say that the only information he withheld and indeed lied about was the common name of the disease, 'cancer', but that everything else was disclosed uncontroversially. He did not misinform the patient about the actual nature of the condition, but merely avoided mention of its misleading, everyday name. With the exception of the 'lie', Brewin could claim to have respected his patient's autonomy and provided all the information necessary for adequately informed consent.

But what seems like a trivial 'detail' to one person may be enormously significant to another, and one could ask Brewin why he did not attempt to explain why the patient's cancer was not a 'shameful, painful, fatal disease that would soon spread.' When a person considers lying, he in part bases his decision on hypothetical projections of the likely effects and repercussions of the lie. These hypothetical projections, based on subjective evaluations of the deceived's beliefs, values and likely reactions, run the risk of error.

Interpreting best interests

Brewin firmly believed that disclosing the diagnosis of cancer would not have been in his patient's best interests. Like Brewin, those in favour of using deception usually invoke the Hippocratic tenet *primum non nocere* (which is encapsulated in the modern principle of non-maleficence) and doctors' obligation to benefit their patients, sometimes referred to as the principle of beneficence[140]. In certain circumstances, these two principles may justify the use of deception for the patients' benefit. Yet although patients and doctors would probably agree that the primary goal of the doctor is to act in the best interests of the patient, there will be some disagreement over what constitutes 'best interests' between and within these two groups. This discrepancy in the interpretation of the phrase is one of the problems for the Hippocratic argument for deception.

Veatch has questioned the possibility of doctors knowing what is in their patients' best interests[141]. Whatever theory of the good one employs, be it hedonistic, desire-fulfilment or objective list theories, the doctor, as an expert in but one aspect of well-being, cannot reliably anticipate what is good overall for the patient. Broadly

speaking, hedonistic theories view what is best for a person in terms of what would make him happiest. Desire-fulfilment theories focus on the satisfaction of a person's desires in determining what is in a person's best interests. Finally, objective list theories claim that some things are objectively good or bad for us, whether or not we like them[142](p.493).

Even under an objective list theory, the doctor is often unable to determine whether a procedure will, for example, further the patient's spiritual or psychological well-being or enhance the quality of his deep personal relationships. Since the doctor is ignorant or uncertain of the relative weight that the patient ascribes to various goods, he must consult the patient before determining whether a course of action really *is* in the patient's best interests. Besides, doctors, as experts in the medical component of well-being, may attribute greater importance to that particular good than other groups. Veatch concludes 'To put it bluntly, the only way to know whether an intervention is good medicine is to ask the patient'[141](p.8).

The effect of perspective on the moral evaluation of lying

Differences in perspective may accentuate the difficulty of interpreting other people's best interests. However well-intentioned, liars tend to overestimate the benefits of the lie on the deceived and underestimate the negative consequences of the lie itself[9 45]. Bok writes:

> Liars usually weigh only the immediate harm to others from the lie against the benefits they want to achieve. The flaw in such an outlook is that it ignores or underestimates two additional kinds of harm -- the harm that lying does to the liars themselves and the harm done to the general level of trust and social cooperation. Both are cumulative; both are hard to reverse[9](p.24).

Robinson, using empirical evidence gathered through questionnaires, supports Bok's observations by showing that people are generally less condemning of lies if they are cast as participants than if they are cast as observers[45]. The perceived wrongness of lying differed in accordance to the status of the participant (i.e., whether the respondent evaluated himself as the liar or whether he evaluated a stranger). This perspectival difference reveals the subjective element in the liar's harm/benefit assessment, and calls for caution in doctors' lies to patients. Doctors who are inclined

to lie should first attempt to put themselves in the position of the patient, as well as consider the broader impact of the lie on themselves as persons and on the public trust of doctors generally.

Metaphors, by reflecting people's attitudes towards a disease or an event, can also provide an insight into their perspective. It is interesting, then, to discover that oncologists employ metaphors relating to physical violence to describe the anticipated 'impact' of disclosing a terminal prognosis. Gordon and Daugherty noted from interviews that oncologists tended to use statements such as

> I don't want to *hit someone in the face* with it [the prognosis]
> *Force it down their throat*
> To just *hammer them* with it
> I don't mean to be *hitting you over the head with this* [the prognosis][143].

These metaphors suggest that oncologists view the decision to give or withhold an unfavourable disclosure as a balance between harms and benefits, and mostly *patients'* harms and benefits. Judging from the nature of the metaphors, the emphasis is on the significant harm that disclosure can cause, rather than its potential benefits. The graphic, physical violence of the metaphors reflects the inner anguish of the informed patient.

Although far from conclusive, such metaphoric language can shed light on the beliefs of oncologists regarding the effect of prognostication that may be more subtle than the explicit affirmation of their views. It is noteworthy that in a profession so known for its love of euphemisms, the informal language of doctors regarding prognosis can be *dys*phemistic (i.e., intentionally using a harsh term or phrase).

Euphemisms are not necessarily deceptive, as long as the recipient is aware of what they refer to. No one is fooled, for example, when people describe a relative as having 'passed away'. In the context of medicine, the term 'neoplastic disease', because it is often meaningless to the patient, may generate further questions and allow the doctor to explain more fully the nature of the condition. Through the patient's questions, comments and answers, the doctor will be able to assess the attitude of the patient regarding the disease and disclose the information in the most

appropriate manner. For patients known or believed to be terrified of cancer, the doctor may wish to invoke the term only after the patient is aware of the prognosis, treatment plan and other medical facts of the disease.

One important point which arises from our discussion of replacing terms such as 'cancer' by 'neoplastic disease' is that true statements can themselves be deceptive. If my doctor tells me something which, although strictly true, is pure gobbledygook to me, and if he does so with the intention to deceive me, then this is deception, whatever the truth-value of the proposition. One counsellor to breast cancer sufferers, who herself had been diagnosed with the disease, recounted how she once saw a woman who said "It's all right, I don't have cancer. The surgeon said it was a tumour" (personal communication, October 7, 2005). Doctors cannot shield themselves from accusations of deception by invoking a strict adherence to the full disclosure of pertinent medical facts.

The value of truth

Does the value of truth invariably transcend all other values, or can some values be more important than truth? For Howard Brody, whatever intrinsic value truth may have can be trumped by another good, respect for persons. Hence he defends the limited use of deception when doing so represents a respect for persons:

> Truth is valuable because in the vast majority of cases, respect for truth is a way of demonstrating respect for persons; but in rare instances respect for persons might demand that the truth be given a lower priority compared to other considerations'[144](p.84).

One could also argue that truth is not *intrinsically* valuable, but is only valuable when used in such as way as to produce a moral good.* On this view, truth should not be considered good for its own sake, but should be viewed as instrumentally desirable to

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* Whether there is such a thing as intrinsic worth or goodness and, if so, how to define it, has long been debated in ethics. Examining this ongoing debate is beyond the scope of this project. For an overview of various approaches to intrinsic goodness, see Feldman, F.[145]

obtain more fundamental goods, such as happiness, well-being, or personal autonomy, whereas truth alone is neither good nor bad.*

Brody's view that truth-telling can be trumped by 'higher' goods is also held by David Thomasma and John Lantos[5 148 5] . Thomasma claims that truth is a secondary good which can be overridden if it clashes with primary values, such as the survival of the community, the well-being of the individual or the preservation of a relationship. Although telling the truth tends to promote these primary values, it does not always do so and in such cases, Thomasma argues, paternalism is necessary[148](p.377).

Lantos believes it is a mistake to assume that people will necessarily be better off knowing the truth[5](p.104). Instead of empowering patients, truth-telling can dump the responsibility onto them at a time when they may not wish to assume that burden and can thus be 'emotionally devastating'[5](p.104). At times, he concludes, 'the best medicine might still be a comforting lie'[5](p.115). In the current climate favouring truth-telling in all situations, Lantos claims doctors do not always tell the truth for the sake of patients -- as respect for persons -- but, consciously or not, to evade accountability and satisfy hospital risk-management teams[5](p.115). In the context of end-of-life care, such defensive attitudes would surely represent a step back in the doctor-patient relationship. Excessive provision of undesired, hurtful information may be as damaging to trust as repeated deception, not only because some patients may not have the time or cognitive ability to assimilate all the information but because the popular perception of the doctor will change. The doctor will no longer be a partner intent on making patients feel better, but a provider of information, devoid of the Oslerian concern for maintaining hope. The nature of the doctor-patient relationship will be radically altered, with perhaps more trust in doctors' honesty but less trust in their good will and desire to improve their patients' health.†

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* Stephen Stich believes that truth is not necessarily an instrumental good[146 147]. Part of his argument rests on the observation that true beliefs occasionally cause more harm than good. To illustrate the point, he gives the example of Harry: Harry has a true belief that his plane will leave on time. He thus arrives in time for take-off. Unfortunately, the plane crashes and Harry dies. If Harry had held a false belief about the departure time, he would not have been killed in the crash. Hence, Stich concludes, 'true beliefs are not always optimal in the pursuit of happiness or pleasure or desire satisfaction'[146](p.123-124).

† I examine the concept of trust on p.102-107.

Like Brody, Thomasma and Lantos, I am inclined to reject the view that truth is intrinsically valuable and to favour the view that truth is instrumentally valuable by virtue of derivative moral goods. Adhering to the view of truth as a solely instrumental good, Schauer comments: 'I am not convinced that the country [the United States] would be, on balance, hurt if American men believed (falsely) that cigarettes and alcohol cause baldness'[149](p.706). Under this view the relationship between truth and moral good is not necessary, but empirical. In other words, while it is *usually* the case that telling the truth and holding true beliefs bring about a moral good, it is not always so. The link is not logical, but strongly probabilistic.

Still, on rule-utilitarian grounds, it might be desirable to make people believe that telling the truth is intrinsically valuable. Indeed, this appears to be what parents do when they emphatically tell their children: "do not lie". Pinocchio's nose elongates whatever the nature of the lie itself. Despite the categorical injunction against lying, the majority of respondents to my questionnaire accepted that deception (including lies) could be morally acceptable in everyday life. As our life experience increases, we acknowledge that there may be instances where lying *is* desirable, where the value of telling the truth is outweighed by the disvalue of what the truth will entail. If we accept that lying may be acceptable, we can either claim that truth has no intrinsic value (it just tends to maximise welfare) or that, although it does have intrinsic value, this value can be outweighed by the disvalue of other factors, such as the consequences of the truth.

Respect for persons

Brody's argument requires an explanation of what the fundamental value -- 'respect for persons' -- means. After all, much abuse in the course of history has been justified on the grounds that it 'respected persons'. Still today, in some countries, women are forced to stay at home, out of sight, to utter few words and to cover themselves up from head to toe. They are not allowed to work or vote. Many supporters of these practices claim that the acts and prohibitions show 'respect for persons'. But what should we mean by 'respect' and 'person'? And what is it about a person that we should be respecting? These are contentious questions, and I shall not dwell on them

in any great detail in this thesis.* Robin Dillon writes that 'there is no settled agreement in either everyday thinking or philosophical discussion about such issues as to how to understand the concepts [i.e., respect and self-respect], what the appropriate objects of respect are, what is involved in respecting various objects [...] and what the scope is of any moral requirements regarding respect and self-respect'[150].

Kant, for example, might reject Brody's claim on the grounds that respecting people amounts to respecting their rational autonomy (i.e., their 'humanity'), and that by lying or deceiving we are undeniably failing to uphold this fundamental value. For Parker, respecting persons is acting 'towards them in ways conducive to their (and our own) flourishing as persons'[128](p.154). In practice, this is characterised by an 'orientation towards a shared understanding', 'respect for the desires and wishes of others (and ourselves)', 'concern for the well-being of others (and ourselves)', 'mutual engagement and interest', 'honesty and authenticity', 'fairness', 'listening and speaking, and by the giving of and listening to reasons', and 'forthrightness and willingness to disagree openly'[128](p.155).

Although the characteristics listed above are laudable, Parker does not discuss their relative moral weights. Is each characteristic a necessary or sufficient condition for an act to count as 'respecting persons'? What happens when two or more elements clash with each other? Can one be dishonest out of concern for the well-being of others and still respect their personhood? It seems to me that concern for the well-being of others is central to respecting persons, and that in the absence of a better, non-deceptive alternative one *can* justifiably deceive others out of concern for their well-being. One can envisage rare situations where a lie, by reducing the likelihood of death or serious harm, will promote a person's flourishing.

Unfortunately, if unsurprisingly, Brody does not explicitly offer a definition of 'respect for persons'. He does, however, conclude his article by stressing that doctors have a 'duty to tell the truth' but that they 'should carefully consider the patient's

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* For an overview of these debates, see Dillon, R.[150] He notes that respect is commonly understood as a mode of positive valuing, a 'mode of experiencing and acknowledging the intrinsic value or significance of something'. He also surveys, amongst other things, the controversy surrounding the scope of the concept of 'person'[150].

needs and desires in deciding whether to tell the whole truth and nothing but the truth'[144]. Perhaps, then, Brody views respecting persons as respecting their needs and desires and this may, but need not, include their freedom to make autonomous choices.

Aside from the Kantian objections, there are practical problems concerning the ability of doctors to ascertain the needs (especially the non-medical ones) and desires of patients. In the hospital setting, when prolonged contact between doctor and patient may be limited, doctors may equate the needs and desires of patients with the 'medical imperative' to treat until medically futile. Doctors run the risk of making quality of life judgements based only on the nature of the medical outcome, while ignoring the patient's own conception of the good. Brody's argument may work when the needs and desires of the patient are clear, but not in situations when there is inadequate information to make an informed judgement about these needs and desires.

Brody invokes a doctor's 'duty to tell the truth' while accepting that concealment and non-lying deception may be acceptable to respect persons. He does not, however, state whether he believes lying is out of bounds.* Would lying necessarily go against respecting persons? And, if so, why should non-lying deception be acceptable but not lies? Finally, if one deems lying to be unacceptable solely because it infringes the duty to tell the truth, then surely the respect for persons is no longer the fundamental value.

Lying, deception and trust in medicine

Is there a moral distinction between lying and non-lying deception? As noted in chapter 3, Kant believed that lying to a person violated the Categorical Imperative and thus could never be permitted[48](p.15). However, withholding the truth or evading unwelcome questions could in certain situations be justified[60](p.426). More recently, Peter Geach (another absolutist against lying), to illustrate how one could rightly evade lying, recounted the story of St Athanasius who, while rowing down the river, encountered his persecutors rowing in the opposite direction. When they asked him

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* Although Brody did not reveal his view on lying in his published article, he expressed his current position in a personal communication (March 11, 2006): "I admit to having more consequentialist leanings in the case of lying, and that in truly exceptional cases, I would consider a lie rather than cause the patient great harm".

for the whereabouts of that 'traitor Athanasius', he replied 'not far away' and rowed away[151](p.114). Another, Augustinian justification for the absolute prohibition of lying rested on the nature of assertions[52]. Assertions were 'designed' to be truthful and thus to deliberately create false assertions was to upset the natural order of things and abuse the very purpose of assertions.

Closer to the present, Chisholm and Feehan anchor their tentative explanation of why lying is worse than other forms of (non-lying) deception on the *right* of the listener to expect that the person asserting a proposition *p* actually believes *p* to be true[36]. A failure to do so constitutes a violation of the listener's *right* to expect truthfulness. Other deceptive strategies, however, do not violate this right and are consequently less morally objectionable. Chisholm and Feehan conclude that 'lying, unlike the other types of intended deception, is essentially a breach of faith'[36](p.153).

Even if we grant that there is such a right, we may question the authors' claim that there is no analogous right applicable to the other types of deception. If there is a right not to be lied to, why should there not be a right obliging people to correct certain evidently false and easily corrigible beliefs in others? If my doctor (or anyone else with the right knowledge), knowing that I have a serious heart condition, does not share this information when I tell him of my plan to climb Mount Everest then he would be required, by this right, to correct my (false) belief about my medical fitness to climb mountains at great heights. A failure to do so would also constitute a 'breach of faith'. The existence of this analogous right could undermine the moral distinction put forward by the authors between lying and non-lying deception. If there is indeed a moral distinction, a more persuasive account of the difference needs to be found.

Some medical ethicists, such as Jackson and Benn, argue that lying is worse than non-lying deception, whereas others, such as Higgs, insist that it is the *intention* to deceive, rather than the form of the deception, that is the crucial factor[6 10 29 152]. For Jackson, the wrongness of lying should not solely be sought in the consequences of the lie to the 'victim', but in the trust that the act of lying undermines. Lies are liable to damage the fiduciary relationship between doctor and patient, which is based on mutual trust. In short, lies tend to threaten interpersonal trust more than non-lying deception. Benn echoes Jackson's argument about trust, and suggests two additional

reasons why lying may be worse than non-lying deception: 1) resisting lies 'requires a greater degree of wily and shrewd self protectiveness' than other forms of deception and 2) people feel a greater 'psychological aversion' to telling lies than telling non-lying deceptions[29](p.133-134). Some of these claims are essentially empirical but, unfortunately, neither Jackson nor Benn provide any empirical evidence to support them.

Kupfer tentatively argues that lying may be worse than non-lying deception since the deceived is 'attacked directly and completely with the shared linguistic instrument'. In lying, he continues, 'we abuse language more flagrantly, using it to produce completely the opposite of what we believe true'[64](p.115). Again, as it stands, I am not convinced by this argument. It requires an account of why violating the Gricean maxim of quality (i.e., 'say what you believe to be true and avoid saying what you believe to be false') is more flagrant an abuse of language than deliberately violating any of the other maxims (i.e., being unclear, irrelevant, or supplying too little or too much information). It is also clear that generating false conversational implicatures can also produce 'completely the opposite of what we believe true'.

Even if it could be shown that lying is a more flagrant abuse of language than other forms of deception, perhaps by appealing to the deceived's additional requirement to infer the untruth in non-lying deception, we still need an account of why a greater, or more 'direct', abuse of language necessarily represents a greater abuse of persons. The deceived's more entrenched cognitive involvement in the non-lying deception (to derive the implicature from the literal statement) does not mean that the deceiver is morally less responsible. He may be *causally* less involved, but not morally so. Indeed, one could argue that making the deceived an unwitting accomplice to his own deception is *more* morally reprehensible than outright lying. Hence for Bakhurst, there is no general moral difference between lying and non-lying deception because both can represent, to the same degree, 'an affront to the patient's dignity and autonomy'[153](p.65).

Bernard Williams avoids making a categorical judgement on the relative badness or goodness of lies and other types of deception[35]. As in his analysis of the acts and omissions doctrine, Williams concludes that the relevance of the distinction to the

moral evaluation of the agent depends on the particular context in which the deceptive act occurs. In some contexts, a lie is morally equivalent to, say, an equivocation, where a person can deceive through an ambiguous use of language. When faced with the murderer at the door, for example, Williams sees no moral difference between lying and non-lying deception if both acts cause the murderer to hold a false belief:

> [...] in the cases we are considering, I deliberately bring it about that he has a false belief, whether I do so by intentionally making a false assertion or by intentionally choosing a misleading one [...] and there, as it seems to me, it makes no difference whether deceit takes the form of lying or of something else[35](p.108).

Earlier in his chapter, Williams considers a hypothetical case of a bystander knowingly allowing a blind man to walk off a cliff and argues that he may be as much to blame as if he had pushed him off [35](p.101). The important factor is not the act or the omission but the relationship between the speaker and the hearer and the ensuing obligations to each other. Truthfulness does not require us to tell the truth to a murderer who is asking for the whereabouts of an innocent child. The murderer, it may be argued, has by virtue of his evil character and despicable intentions waived his right to honest communication. Hence, in this context, whether the dishonesty takes the form of a lie or a non-lying deception is irrelevant.

In other contexts, as when a person self-interestedly lies to a trustful hearer, lying may be morally worse due to the abruptness of the violation. Williams writes: 'In the lie this substitution of the will for the world (i.e., giving the hearer a picture of the world resulting from your will) becomes as immediate as it conceivably can be'[35](p.118). But Williams does not explain why immediacy should make lying worse if the intent is identical. Perhaps this immediacy makes lying less bad than the insidious, drawn out 'substitution of the will' characteristic of other types of deception.

The principle of honesty

Veatch counters the arguments against truth-telling by proposing the inclusion of another principle, the principle of honesty, which would act as a constraint against the use of deception, however beneficial to the patient, *unless* the patient established 'a

general consent for the physician to withhold or even lie at some point in the future if the physician believed it would benefit the patient'[154](p.218). Veatch's principle requires doctors to be honest, not merely to tell the truth, based on the special contractual relationship between doctor and patient. As discussed in chapter 2, telling the truth can still be dishonest if the speaker intentionally violates Gricean maxims to mislead the hearer. Withholding information that a reasonable patient would expect in the circumstances is, for Veatch, conceptually equivalent to an omission of beneficial medical treatment. In both cases, the doctor is as responsible for the omission as he is for the action, since he has failed to abide by the conditions set out in the implicit contract between doctor and patient. For this reason, Veatch sees no moral difference between withholding information and lying in situations where honesty is reasonably expected. This thesis will show, empirically, whether the stakeholders support this view (see p.204-208).

Proponents of the Four Principles, such as Beauchamp, Childress and Gillon, are likely to include Veatch's principle of honesty within the principle of respect for autonomy. Yet this does not mean that they would view such a principle as absolute. It would still have to be weighed against the other prima facie principles.

Søren Holm's study on the ethical reasoning of doctors in Denmark, based on an analysis of 42 semi-structured interviews with doctors and nurses, identifies a variety of patients' rights mentioned by his respondents, including the right to be told the truth[17]:

> The duties and rights identified here are not seen as absolute; all of them (*with the possible exception of the right to be told the truth*) can be superseded by other considerations[17](p.123-124) (emphasis added).

Unfortunately, Holm did not expand on the content of the 'right to be told the truth' or explain why he qualified his claim with a precautionary adjective ('possible exception') but his findings suggest that some doctors and nurses held the view that the principle of honesty is invariably overriding and that deception is never morally acceptable. This absolutist position, however, does not seem plausible. Indeed, even the Kantian Categorical Imperative can allow some exceptions to the principle of honesty in medicine.

Applying the Categorical Imperative to deception in medicine

In chapter 3, I examined the relationship between lying and Kant's Categorical Imperative (CI). I argued that universalisable exceptions to lying were logically possible in situations where the deceived is unaware of specific information possessed by the liar. The murderer at the door who does not know that you recognise him as the murderer from the evening news is an example of a universal law against lying which would not annul itself. Are there circumstances in which deception in medicine could be justified in universalisable maxims consistent with the Kantian CI?

As I described in chapter 3, a maxim should contain both an act and an end (e.g., deceiving to further the best interests of the patient). To satisfy the Formula of Universal Law (FUL), a maxim containing deception will need to be specific to avoid contradiction. Consider the following maxim:

Maxim 1: doctors' deceiving patients when they believe it is in patients' best interests

The maxim is clearly too general. In a world in which all doctors acted according to the maxim, there would surely be scant trust in doctors. The doctors' lies would most probably not be believed, and neither would their truthful statements. A doctor willing that the maxim become a universal law would, for Kant, be willing the failure of his own deception. To stand a chance of passing the FUL test, a maxim requires explanatory or clarifying clauses. Hence a more promising formulation would be:

Maxim 2: doctors' deceiving patients when they are convinced that telling the truth is likely to cause grave and permanent injury to the patient's physical or mental health which may be significantly reduced in gravity or avoided by a benignly intended deception and when the patient has expressed, overtly or implicitly, a wish to get physically or mentally better, and when other non-medical considerations (e.g., patient's views, relatives' views, patient's life plans) that may influence the decision to deceive have been properly considered.

Could I accept a world in which everyone in the situation applied maxim 2? Certainly, although others with less trust in the medical profession would no doubt disagree. In theory at least, maxim 2 seems like a reasonable law that could be universalisable without contradiction and without undermining the general trust in the medical

profession. Trust in the doctors' word might be minimally affected but not trust in doctors' ability to improve patients' well-being and reduce suffering. Indeed, one may wish to add a clause stating that if the patient explicitly asks the doctor to tell the truth about his condition, then the doctor should provide it, irrespective of the potential harm ("please tell me the truth doctor, do you think I'm going to die on the operating table", the tearful, distressed patient with a ruptured aortic aneurysm asks the unhopeful anaesthetist). This would provide another safety net for those patients who are worried about being deceived. Even under Kant's FUL, universalisable exceptions to lying (or deceiving) can be found if sufficiently detailed.

In *Truth and Truthfulness*, Bernard Williams contemplates the possibility of a rule against lying and supports the claim that a plausible rule will contain multiple exception clauses:

> If there were a rule, what would it be? If it were merely a rule against lying, or against deceit more generally, it would be a rule with many and various exceptions, since there are all sorts of cases in which the best thing to do is to deceive [...][35](p.121).

For Kant, a maxim must also adhere to the Formula of Humanity (FH) since the duty to respect autonomy trumps all else, including the duty of benevolence; we cannot violate people's humanity just because we think this is in their 'best interests'[48]. Unless there is good evidence that the person lacks rational autonomy, we should assume that the person would want to know important information about his situation in order to make an informed decision regarding his best interests. So are *all* lies forbidden under the FH or can exceptions be found?

Korsgaard, in her double-level Kantian theory, argues for an exception to the FH when fighting a 'very great natural or moral evil'[63](p.152). There is some vagueness surrounding the definition of 'very great evil' but a case can be made for placing severe disease within that category. Although it is not another rational agent who is causing the evil, the pathogenic agents are undermining the patient's autonomy by threatening his very existence. Life, after all, is a necessary condition for autonomy. The greatest way to respect a person's rational autonomy, as long as we have good reason to believe that this person wishes to have his life prolonged, would be to

ensure his survival to allow him to continue exercising his autonomy. Now Kant would have objected to this view, since the CI clearly delineates one's sphere of responsibility[49](p.64-65). For Kant, once the agent has respected the CI, the consequences of his actions -- including the death of a patient or of an innocent Jew hidden in his house -- are no longer his problem.

However definite, Kant's 'sphere of responsibility' is intuitively too narrow. The doctor who tells the truth to a frail patient, knowing that this may well cause a life-threatening myocardial infarction, cannot realistically hide behind the excuse that he only fulfilled his duty to be honest (as stipulated in the GMC guidelines) and that, consequently, he is in no way morally responsible for the patient's death[13]. There comes a point when the link between the act of truth-telling and the consequences is so close that the sphere of responsibility must also extend to the consequences.

A difference between violating the autonomy of the murderer and that of the patient is that, in the former, the violation is in defence of self or others whereas in the latter the purpose of the violation is to maintain the long-term autonomy of the deceived and, in some sense, to defend him against predicted adverse consequences of truth-telling. The 'very great evil' does not affect you directly, but the patient. One could argue, however, that as the patient's doctor, tackling the evil is as much your responsibility as it is your patient's. You are a team -- a partnership -- fighting a common evil and if, *in extremis*, one partner needs to sacrifice the other's arm to save him from the lethal grasp of the enemy, so be it. The one who gains from the lie differs in the case of the murderer and the patient. In the case of lying to the patient, it is the deceived who derives the benefit of the lie (although the liar may also derive satisfaction from the act); in lying to a murderer, it is the liar or some other party who benefits. Unless the patient autonomously refuses to be helped, temporarily violating the autonomy of a patient to avoid a life-threatening evil is arguably more virtuous and altruistic than lying to preserve your own autonomy in the face of great evil.

Aside from the theory's uncertain domain of applicability resulting from the vagueness of the phrase 'very great evil', one problem is that the appropriate application of the exception clause assumes an ideal situation, where all the relevant factors, such as the magnitude and likelihood of the evil, are known. In real life, the

decisions are made with incomplete information, based on the doctor's judgement of the likely harms and benefits. The reliance on subjective, probabilistic judgements runs the risk of applying the exception clause when there is insufficient evidence to warrant it. Misapplication of the clause can lead to loss of trust in the partnership, worse physical and emotional outcomes than the honest alternative, and regret on the part of the doctor. The inherent difficulty in making such judgements and the potential effects of a misapplied deception can lead to a rule-utilitarian type of position against all forms of deception.

Jennifer Jackson, although acknowledging that some lies (such as those to save one's life or to protect a confused patient from self-assault) may be permissible, also expresses distrust in the ability of doctors to stick to the exceptions[6](p.89-91). She thus proposes a 'zero tolerance' teaching to avoid sliding down a slippery slope where acceptable lies will invariably lead to unacceptable ones[6](p.133).

Merely as a means

In chapter 3, I employed Parfit's interpretation of what counts as using people merely as a means to argue that deception need not necessarily violate the FH. Parfit claimed:

> We do *not* treat someone merely as a means, nor are we even close to doing that, if either (1) our treatment of this person is governed or guided in sufficiently important ways by some relevant moral belief or concern, or 2) we do or would relevantly choose to bear some great burden for this person's sake[67](p.77) (his emphasis).

Two conditions can be extracted from the description. An agent does not treat another merely as a means if

1. *The deceived could have rationally consented to the deception, prior to the act* (Parfit's Consent Principle). This is sufficient to count as a relevant moral concern.
2. *The agent is putting himself to some considerable effort or at significant risk for the sake of the deceived.* This is enough to show that the agent is not treating the person merely as a means.

It is possible to imagine a doctor deceiving a patient invoking either of the above conditions. In case 6 of the questionnaire, in which the doctor does not know whether to disclose a cancer diagnosis to a cancerophobic patient recovering from a heart

attack, a 'reasonable' patient could have rationally given his consent to the deception, before these unfortunate events, if he had known that the deception might spare him another heart attack and possibly his life. Whether *that* particular patient actually would have consented is another matter; the important point is to ascertain whether he would have had sufficient reason to consent. In this case, it seems reasonable to assert that the reasons -- the prevention of another heart attack and associated complications -- are sufficient, if not necessarily decisive.

Finally, the doctor is putting himself at significant professional risk for the sake of his patient as he is infringing the dictum of the GMC: 'be honest and trustworthy'[13]. If the deception is discovered, he may be reprimanded by colleagues or official bodies. Furthermore, he may be criticised by the unusually truth-loving or doctor-hating patient himself. He may be sued or struck off the register. He may be feeling pangs of guilt for his non-disclosure, despite believing that it was the right thing to do. He may be concerned about undermining the all-important trust between doctor and patient. In sum, the doctor is risking much for the sake of his patient and this is enough to show that he is not treating him merely as a means.* His altruistic motives, his respect for the Consent Principle, and the potential costs to himself dispel any hint of indifference or contempt associated with Kant's concern. He is not treating the patient as a mere tool to further his own ends. He does value the patient *qua* person. In certain circumstances, then, a doctor may deceive a patient while treating him as an end-in-himself. He is still treating the patient as a means but, crucially, not *merely* as a means.

Trust, truth and truthfulness

As the title of Williams's *Truth and truthfulness* suggests, truth and truthfulness are two different concepts, although both are linked[35].† Truthfulness may require telling

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* One can also imagine a doctor who deceives because it is the easier option, especially if he has made a mistake. In this case, he would not be deceiving for the sake of the patient and condition 2 would not be satisfied.

† To the likely discontent of postmodernists, radical sceptics and deniers of truth, I shall follow the practice of Bok and Barnes and ignore the perilous domain of the philosophy of truth[9 23]. Besides the 'formidable exegetical task' that an account of truth-telling sensitive to postmodernist thought would require, this study is concerned with ethics rather than the metaphysics of truth[23](p.13). The focus of the project is on truthfulness. The question of whether or not to tell what one believes to be the truth

what one *believes* to be the truth and the genuine attempt to abide by the Gricean cooperative principle. Whereas truth is an abstract term devoid of any intrinsic moral elements (i.e., the fact that proposition X is true does not inform us on the moral desirability of X), truthfulness is laden with positive moral connotations. Furthermore, although one can ascertain whether, for example, the sky is blue by simply looking at the sky, one cannot assert that someone is truthful by merely examining the truth-value of his propositions (recall Williams's 'someone has been opening your mail' example mentioned on p.29). The assessment of truthfulness involves the consideration of many additional factors. What is truthful in one context may not be so in another. It depends on the pragmatics of the situation, the intention of the speaker, the background assumptions and expectations of the participants, and so on.

While Williams is primarily interested in truth and truthfulness, it may be worth dwelling on another pair of concepts: trust and truth. Can there be trust without truth? Can I (and, if so, should I) trust a person who doesn't always tell the truth? Alternatively, can I (and, if so, should I) distrust someone who always tells the truth?

It is perhaps best to start by considering the meanings of 'trust'. In everyday language, the word is used in contexts such as 'to trust that X', 'to trust a person', 'to trust a person to X', and 'to entrust with'. As Cooper notes, the assertion 'Jones trusted Dr X' can be dissected into the following meanings:

A. Jones entrusted Dr X with, for example, personal information
B. Jones believed Dr X to be trustworthy
C. Jones felt confidence in Dr X's medical competence/honesty/etc[156]

Although all these meanings are related, a distinction must be made between to 'entrust', which is an *act*, and the other uses, which reflect *epistemic attitudes*. A common thread running through these meanings is the strong belief that something will occur (or be the case) or that someone will do what he is expected to do. Yet, more than merely expectation, trust often contains an emotional component, which explains why we often feel betrayed when our trust has been abused (by an agent or institution). The feeling of betrayal is usually accentuated by the fact that those who

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does not require an account of the various theories of truth. Gillon supports this when he points to the 'fundamental confusion between the moral issues of truth telling and truthfulness on the one hand and the epistemological, logical and semantic problems that beset the concept of truth itself'[155](p.104).

need to trust are in a position of vulnerability. Hall *et al.* comment that 'trust is inseparable from *vulnerability*, in that there is no need for trust in the absence of vulnerability'[157](p.615) (their emphasis). An abuse of trust by a friend forces us to modify -- or at least reconsider -- our feelings and attitudes towards him. In the absence of good reasons for the abuse, the nature of our relationship may change substantially. So what is the importance of trust, and in particular trust in doctors? And how does lying or deception undermine, or indeed maintain, trust?

As no person is entirely self-sufficient, trust is instrumental to one's flourishing as a person and, more generally, to the proper functioning of society. To function as individuals and as a society, we must rely on others to act in certain ways and they too must rely on us. As I wrote in chapter 3 (p.35), without trust in people's truthfulness, we would be unable to make reliable decisions about our lives and society would soon collapse under mass confusion. For LaFollette, trust is thus 'essential for personal relationships' and constitutes 'the foundation of social order'[158](p.114-115). Bok is even more emphatic: '*whatever* matters to human beings, trust is the atmosphere in which it thrives'[9](p.31) (her emphasis).

In *Truth, trust and medicine*, Jennifer Jackson refers to the practical importance of trust in the doctor-patient relationship, and denounces even benevolent lies as detrimental to that trust[6]. Trust -- and by this I refer not only to patients' trust in doctors but also doctors' trust in patients -- is in many ways instrumental to the success of medical practice and medical care, both at the micro level of doctor and patient and at the macro level of the population's health needs.

Whatever their illnesses, patients usually go to the doctor to get better. They believe that doctors will use their knowledge of medicine to that effect. They entrust themselves to the skills of the doctor, whom they believe (or trust) will do his best to improve their physical or psychological well-being. Based on this trust, patients can reveal even the most personal or embarrassing details to doctors safe in the knowledge that no unauthorised persons will hear of them. Without this trust, however, patients may decide not to visit the doctor at all or, if they do, they may be more reluctant to share their concerns with their doctor. Lacking all the necessary

information, the doctors will struggle to make an accurate medical judgement or suggest the most appropriate treatment.

Open communication between a doctor and patient will engender a deeper relationship between the two parties, allowing the sharing of values and preferences which may give the doctor a better idea of what constitutes the 'best interests' of the patient. The doctor can then treat the patient in light of the latter's fundamental values. Trust, by encouraging cooperation and fostering deeper relationships between doctor and patient, can therefore affect the therapeutic success of the consultation.

But how can we explain, as Jackson asks, the trust patients had in their doctors in days when doctors presumably deceived more than they do today. In the first few decades of the 20th century, for example, there was tremendous public trust in doctors, although the duty to inform was less binding than it currently is[159]. Patients may not have known that doctors often deceived them or, if they knew, perhaps trusted doctors in the sense of improving health rather than trusting 'their word'. Perhaps patients trusted doctors to 'do the right thing', including deceiving them about grim prognoses if they believed such deceit was in their interests.

Today, doctors may be more truthful (and, as a result of the many rules and regulations which they must follow, more trustworthy) but it does not follow that people trust them more than in the past[90](p.137). Patients may have more trust in doctors' honesty in sharing information or following the relevant guidelines but less trust in their ability to fulfil their expectations. Trust is more specific than the isolated word suggests; one trusts someone, to different degrees, to perform (or not perform) a certain act. If, following a pre-operative meeting with my surgeon, a friend asks me 'do you trust him?', I infer that he is referring to the surgeon's ability to competently operate on me, not his ability to cook a hearty coq-au-vin. Trust can also have multiple referents. I can have a high degree of confidence in my doctor's honesty, but little confidence in his ability to successfully treat me. So, although my trust would be diminished in the knowledge that my doctor may be deceiving me, my trust in his clinical skill may *in theory* be unaffected. When someone asks 'do you trust me?', he is leaving out an elliptical clause such as 'do you trust me [to remember the shopping/to recommend you a good car/to safely borrow your computer].

So what are the referents in the context of the doctor-patient relationship? What would the 'trust' refer to in the question 'do you trust your doctor'? A plausible answer would be to the doctor's ability to address your health concerns in a satisfactory manner. This might encompass being medically competent, prescribing the appropriate medication, providing adequate information in an understandable form and fulfilling basic requirements of politeness, compassion and honesty. Failure in any one of these aspects would to some degree erode the overall feeling of trust between doctor and patient. In this context, it therefore seems more accurate to talk of referents of trust rather than a single referent. Mechanic and Meyer, in their study on patients' concepts of trust, cite an interviewee whose answer demonstrates the range of referents of 'trust':

> Trust means that there's confidence in a person. That I know they'll do the right thing that's in my best interests. That the person's well trained. That they've had previous experience working on this particular type of medical problem. And that they're up-to-date on the latest technology, latest research. And that they treat you as an individual, as opposed to just another patient[160](p.660).

Hall *et al.* derive five objects of patients' trust in doctors:

1. Fidelity (i.e., considering the patient's best interests)
2. Competence
3. Honesty
4. Confidentiality
5. Global trust (i.e., the overall, irreducible 'feeling' of trust)[157].

Trust thus appears to refer to a cluster of abilities and attitudes which combine to form the object of our overall or 'global' trust. Patients may vary in the importance they attribute to each component (e.g., a person may trust an ethical but technically incompetent doctor more than a technically competent but unethical doctor), but I suspect every patient will attribute *some* importance to all of the components. The components are also interrelated, since the absence of one weakens the solidity of the overall structure. All other things being equal, a patient will probably have less trust in a doctor who communicates in an obscure, jargon-rich way than one who imparts the same information clearly. This fact points to the importance of non-medical aspects of doctors' competence in building and maintaining patients' general trust.

Even if we accept that honesty is a key component of overall trust, the doctor need not be truthful *at all times* but simply enough of the time to convince the patient that he is indeed honest and to ensure the cooperation of the patient. However, as a side-effect of the interrelatedness of the components of trust, it would not be surprising if in the minds of many patients a doctor's honesty is linked to his medical competence. The reasoning, however fallacious, would go 'if I can't trust my doctor to tell me the truth about my condition, then why should I trust him in other areas?' (and vice versa). Indeed, this is supported by Hall *et al.*, who write:

> Most patients have difficulty assessing technical competence directly, so their views of competence are heavily influenced by a physician's interpersonal competence (communication skills and bedside manner)[157](p.621).

Yet although doctors' dishonesty may sometimes damage patients' trust in their abilities to make them better, overall trust is unlikely to *require* an atmosphere of complete truth-telling and may be consistent with accepting benignly intended deception in some circumstances. To say that one trusts a friend, for example, does not entail that one expects that friend to always tell the truth. There are times when we seek encouragement and support from friends rather than the unvarnished truth. There are times when true but potentially wounding comments are better left unsaid. The philosopher David Nyberg comments: '[...] it seems to me that communication absolutely free of deception of all kinds is suitable only for people who like each other very little, or don't plan to be together very long'[33](p.80).

Furthermore, honesty may lead to *distrust*. A doctor who admits each of his mistakes, however minor, repeatedly shares his doubts and uncertainties, and outwardly worries about the effectiveness of a treatment may damage another type of trust, notably trust in the doctor's competence. As Hall *et al.* point out, 'Paradoxically [...] increased honesty might lower trust in other dimensions'[157](p.622). It is a mistake to blindly associate honesty with overall trust. The latter results from a mixture of various components, of which honesty is only one part.

In light of the above, it seems problematic to blindly equate deception (and even lies) with distrust, not just between friends and partners but also in the context of the doctor-patient relationship. Although there might be a correlation between trust and

truth, one can still trust a person in the knowledge that he may, at times, withhold true feelings or even lie. The absolutist interpretation of the moral principle 'tell the truth' is not only simplistic and reductive, but can also be harmful. My feeling is that doctors' 'truth dumping' -- revealing any information which the patient might want to know, irrespective of the situation -- may be more damaging to overall trust than the highly selective use of deception. Like Brody, I believe that *not* telling the truth may occasionally represent a greater respect for the well-being of persons than truth-telling[144]. Furthermore, such benevolent deception is not treating the patient merely as a means. Deception, including lying, can be morally desirable if it promotes more fundamental moral goods. The key problem is identifying, explaining and justifying these rare circumstances when deception may be preferable to truth-telling.

CHAPTER 5

Evolutions and Variations in Truth-Telling and Deception in Medicine

In the two preceding chapters, I examined the issues of lying, deception and truth-telling in moral philosophy and medical ethics. In this chapter, I shift from theory to practice and focus on how doctors have dealt -- or claimed to have dealt -- with truth-telling issues 'at the bedside'. For the sake of clarity, I have adopted a chronological approach, starting from Hippocratic times and finishing with current practice.

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'[161](p.55)[162](p.297).* 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'[162](p.299).

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?[164](382b-382d)

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* This advice still holds true today. Burgoon *et al.* reported that 85% of the patients they interviewed admitted concealing or equivocating about information to their doctors, and roughly a third claimed to have occasionally lied to their doctors[163](p.461).

Plato draws an analogy between lies and medicines, as both may be used instrumentally 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.*

In the 18th century, John Gregory considered lies and deceptions to be morally justified when used in the patient's best interests, and so too did Thomas Percival. So influential were Percival's views that the American Medical Association 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 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[165].

Percival equates a harmful truth with a medical mistake. According to the code, disclosing a 'gloomy prognostication' is poor medical practice in all but a few exceptional cases. Through a two-step process, Percival draws a causal link between disclosure and a shorter life: disclosure leads to loss of hope; loss of hope leads to a shorter life, therefore disclosure leads to a shorter life. 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.

An argument against lying was offered by a contemporary of Percival, Reverend Thomas Gisborne (1758-1846), who anchored his distaste for the practice on grounds of conscience and on the observation that lies usually fail to convince

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* The analogy, however, does not quite work. An important difference between a drug and a 'therapeutic lie' relates to the possibility of consent. For a therapeutic lie to succeed, the doctor must arguably have a trusting, unsuspecting patient who will respond in the desired manner to the falsehood. Unless the patient has explicitly or implicitly requested to be lied to in such circumstances, no consent for the 'lying treatment' can be given.

patients anyway[166]. Instilling hope should be encouraged only 'as far as truth and sincerity will admit'[166]. Furthermore, Gisborne argued, 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[6](p.18).

Disclosing grim news may not necessarily lead to loss of hope. This was the view of Richard Cabot (1868-1939) who, based on his own experience as a doctor in Boston, 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'[6 167 168]. This view was also held by Worthington Hooker (1806-1867) a few decades earlier, who also emphasized the 'indirect and collateral effects of deception' on others and on the medical profession as a whole[169](p.75). Although he objected to lying to patients, Hooker did however believe that there are cases where 'we [physicians] should [...] take pains to withhold knowledge from the sick, which we fear might be injurious to them'[169](p.78).

The view that the benefits of lies to the patient are outweighed by their harms contradicts Percival's second assumption (loss of hope leads to a shorter life). The loss of hope need not lead to a premature death, but as a transient phenomenon can be replaced by either stoicism or even optimism. Under Percival's belief that emotions affect health, these attitudes may have a positive impact on the patient's quality of life and life expectancy.

William Osler (1849-1919), probably the best known doctor in the Western world at the turn of the century, appeared to favour both arguments. He seemed to advocate truth-telling in some situations although he emphasised the importance of maintaining hope in the patient. In a 1907 issue of the St Mary's Hospital Gazette, he wrote 'Once gain the confidence of a patient and inspire him with hope, and the battle is half won'[170]. 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[171](p.901).

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[7](p.265). Nevertheless, the passage also reveals that Osler, like Cabot, believed in the possibility of disclosing gloomy news to patients while maintaining hope.

Like Osler and Percival, 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[172](p.54).

Although in favour of withholding the truth from certain patients, Lord Cohen 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.'[173](p.111). 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[173](p.111).

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. Kenneth Lane, in his autobiographical account of life as a GP in the 1930s, mentions prescribing the 'latest bit of fashionable nonsense'[174](p.110). The historian Edward Shorter notes that most of the drugs used in the early part of the 20th century were known to be -- or subsequently discovered to be -- no more than placebos[175](p.155-157). For psychosomatic conditions, these 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"[175](p.157). 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[176](p.794).

As for what patients expected of their doctors, little is known. The literature of the period offers some insights. Methven analysed representations of doctors in fiction from 1858 to the turn of the century[177]. Drawing on a large body of fiction, he found that novelists regarded doctors' 'scrupulous honesty' as an overwhelmingly desirable attribute[177](p.82). A doctor's worth was not measured by his clinical acumen but in terms of his ethical character. How much these conclusions based on literary texts are representative of the general population is difficult to assess, but they may point to a discrepancy between what many doctors considered good practice (deceiving patients in certain circumstances) and what patients considered so (scrupulous honesty).

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 United States[178]. 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'. A more accurate description might have been '*anticipated* unfavourable emotional reaction'. This is the same reason invoked by Thurstan Brewin when he lied to his 90-year-old cancerophobic patient[16](see p.82 of this thesis). The second most cited reason in the survey was the patient's family's request not to inform, reflecting a time when relatives often knew a diagnosis or prognosis before the patient.*

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[178](p.903).

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* 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[178](p.902).

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[179].

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. As Shorter notes, the typical patient 'was willing to tolerate, indeed expected, a kind of medical tyranny that today would produce shocked exposés in the press'[175](p.171).

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[8](p.1120). 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[8](p.1123).

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[135](p.119). The result of this propensity to withhold the truth from dying patients in American hospitals 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.* If the patient was unaware or suspicious of the grim prognosis, 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,

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* Glaser and Strauss's study was based on field observations and interviews done at several hospitals in San Francisco (USA) over a period of three years.

ranging from direct questioning to the observation of the nurses' behaviour, to uncover the desired information.

By the late 1970s, however, 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[180]. With the unsurprising exception of paediatricians, there were no differences between medical specialities in attitudes towards disclosure. The respondents saw age, intelligence, relatives' wishes about informing the patient, and emotional stability as the four most important factors in deciding whether or not to tell the patient. The study also showed that medical schools were more likely to deal with these issues than previously. Whereas only 7% of Oken's respondents indicated that their policy on disclosure was influenced by their medical school teaching, 24% of Novack *et al.*'s respondents mentioned it as a source of influence. Twenty four per cent is still low, however, and with the strong emphasis on communication skills in many medical schools, the figure today would probably be higher.

Although their survey suggests a reversal in dominant attitudes, Novack *et al.* only obtained a 40% response rate to their questionnaire (278 usable surveys out of 699 sent). It may be 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. As I mentioned on p.79, Miyaji showed 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 a patient[15]. This is in part explained by the doctors' indeterminate interpretations of key concepts such as 'truth', 'rights', 'duties' and 'hope'.

Finally, the studies by Oken and Novack deal only with diagnosis of cancer, not prognosis. Both Miyaji and Christakis have shown that doctors usually emphasize treatment and downplay prognosis[11 15]. It is, after all, much easier for doctors to tell a patient that he has a cancer and then describe the available therapeutic

options than telling him this *and* that he probably has a few months to live. Miyaji writes 'If patients don't ask any specific questions, many doctors interpret this as an indication that the patient does not want to know'[15](p.252). The present study supports this observation (see chapter 8).

A major difference between disclosing cancer in the 1950s and early 1960s, and doing so in the late 1970s, is that in the former period a diagnosis of cancer quite often entailed, and was widely perceived by the public to entail, a terminal prognosis. When this association abated, partly as a result of earlier and better diagnostic procedures, more effective treatment, and greater public understanding of cancer, it became possible to reveal the disease without revealing the prognosis. By the late 1970s, people were generally aware that a diagnosis of cancer did not entail a 'death sentence'. 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.

Even with the caveats in mind, Novack *et al.*'s study appears to expose a change from Oken's earlier study, although the magnitude of the change is debatable. This shift, which occurred in less than 20 years, reflects in part broader societal changes in the United States, and indicates the impact and relevance of social context on professional attitudes. The perceived acceptability of truth-telling and deception, it seems, is dependent on the state of the doctor-patient relationship, which is itself subject to change. 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 now 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.

Lantos attributes the current, greater inclination to tell the truth to four major changes in the practice of medicine[5](p.86-89). The first is the advent of diagnostic tests revealing the presence of disease prior to the recognised physical

manifestation of symptoms. The patient, Lantos claims, is not acutely ill and seeking reassurance, as was most often the case in the past, but in search of statistical information with which to make an informed choice. The second is the toxicity of many modern medical treatments, such as chemotherapy, which necessitates informed consent. The third is the increased choice of suitable therapies brought about by improvements in the field of clinical epidemiology.* Faced with many choices, all presenting different advantages and disadvantages, decisions must be made in accordance with the patient's own evaluation of the benefits and harms of each option. The final change is the 'incorporation of a progressive mentality' in medicine, which has led to the development of ethical guidelines to accompany medical research[5](p.88). Research participants must be informed of the implications of the research on their well-being. All these changes, Lantos claims, were partly fuelled by lawyers and judges through malpractice cases.

I suspect there is another reason why truth-telling is more prevalent now than previously. Patients are, on the whole, much more informed about medicine than ever before. Books, magazines, leaflets, television and the Internet are all sources of information that would not have been accessible -- or *as* accessible -- even a few decades ago. This ease of access to information arguably makes it harder for doctors to successfully deceive their patients.

I would also emphasise, within Lantos' fourth criterion of 'progressive mentality', that the relationship between doctors and patients has shifted from one of typically unquestioning acquiescence to a more levelled 'partnership'. The shift from a largely paternalistic model to an autonomy model, which started roughly in the late 1960s in North America with the general questioning of authority figures, has empowered the patient by giving him an authoritative voice in medical decision-making[182](p.116-117). The permissibility of doctors' deception, as part of a generally disfavoured paternalism, has also been affected by the advent of this new mentality, and a more complete and truthful disclosure has emerged.

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* Clinical epidemiology is the study of the diagnosis, prognosis and evaluation of treatment[181].

Although I have focused on North America and the United Kingdom, the use of deception in medicine varies widely across time, cultures and geography[183-185]. Around the time of Novack's study, for example, many doctors in medically developed countries outside the United States continued to withhold adverse diagnoses from patients. 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'[186]. In the interviews I conducted for this research, some oncologists could still recall a time -- not so distant -- when a diagnosis was not always disclosed in England. One oncologist said:

> Generally by the time a patient's referred to an oncologist they know they have a cancer. It's extremely unusual now to find a patient who isn't aware of that, although going back ten years that was still surprisingly common.

Current patients in the United Kingdom and the United States may know they have cancer but may not be aware of its severity. In a 1997 study on the attitudes of surgeons towards the psychological aspects of surgery, Burton and Parker found that only 37% of the 51 surgeons interviewed had a policy of *always* telling a patient about the presence of malignancy.* Fifty five percent were guided in their disclosure by their perception of the wishes of the patient *or his relatives*[187](p.50) (emphasis added).

A more recent study by Christakis, involving 365 American doctors predicting survival in 504 cancer patients, suggests that doctors usually do not communicate their 'best and most objective' prognostic estimates to their patients[11](p.122-123). 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[11](p.122). The rest of the time, they would give a deliberately optimistic estimate or, less often, a pessimistic estimate[11](p.123).†

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* However, although published in 1997, the empirical research was conducted in the mid to late 1980s.

† Christakis found that only 20% of predictions were objectively accurate (i.e., within 33% of the observed survival). Sixty three per cent of predictions overestimated survival, while 17% underestimated it. Interestingly, the better the doctor knew the patient (determined by length and

From a global perspective, the disclosure of cancer diagnosis is rare in some countries but common in others. Hamadeh and Adib revealed that only 47% of Lebanese doctors working with cancer patients usually disclosed a diagnosis of cancer[184]. In Singapore, Lee and Pang showed that 40% of terminally ill patients surveyed had not been told of their diagnosis[185](p.533), while Fan and Li, in 2004, commented that

> Chinese medical ethics, even today, in theory and in practice remains committed to hiding the truth as well as to lying when necessary to achieve the family's view of the best interests of the patient[188](p.180).

About disclosure practices in Greece, Dalla-Vorgia *et al.* write that 'The belief that the Greeks, as a Mediterranean people, are very sentimental, cannot accept a cruel truth and might react very badly was -- and still is -- shared by many doctors'[189](p.67).

The Japan Medical Association (JMA), in its recent Professional Ethics Guideline for Physicians (2004), asserts that, although doctors have an obligation to inform patients of their illness, 'it is permissible to withhold the truth from the patient on exception; when a justified reason exists such that directly disclosing a patient's true diagnosis and symptoms will cause severe psychological shock to the patient and may impact further treatment'[190](p.10). Nonetheless, the JMA recommends that doctors who withhold the truth from a patient must inform the patient's family[190].

Even within a limited geographical area, people with different ethnic backgrounds can differ in their views on truth-telling. Blackhall *et al.*, in an ethnographic study carried out in urban Southern California, showed how European-American and African-American respondents on the one hand, and Korean-American and Mexican-American respondents on the other, viewed truth-telling in varying ways[191]. The former group tended to associate truth-telling with patient empowerment, whereas the latter group was more likely to view the practice as cruel and harmful to patients.

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intensity of contact), the higher the chance of a wrong prognosis, usually by overestimating survival[11](p.67).

The Navajo Indians present a particularly interesting case of a culture at odds with the dominant Western tendency to disclose bad news. Traditionally, Navajos believe that language and thought shape reality and influence future events[192]. Some Navajo patients therefore consider open discussion of a bad prognosis as positively harmful to their chances of recovery, as it is not anticipating a possible future but *creating* one.* This can be a problem when Navajos are treated in hospitals subscribing to Western bioethical norms. The very mention of side-effects, which in Western culture is necessary to obtain informed consent, is enough to dissuade some Navajos from even a life-saving medical procedure. Carrese and Rhodes quote a Navajo nurse whose father had consulted a surgeon about a bypass operation:

> The surgeon told him that he may not wake up, that this is the risk of every surgery. For the surgeon it was very routine, but the way my Dad received it, it was almost like a death sentence, and he never consented to the surgery[192](p.828).

Violating in such a direct manner the strongly held beliefs of Navajo patients may run counter to their best interests. The Navajo example illustrates the futility and, indeed, the danger of mechanically applying a simplistic set of rules to the medical setting. Although general guidelines would be useful as rules of thumb, they could never entirely replace a doctor's personal judgement. A cross-cultural look at truth-telling attitudes and practices strongly suggests that, in some cultures, benignly intended deception is widely accepted and that an absolutist rejection of such deception could be very harmful. Absolutists against deception must confront and respond to these observations.

Summary

In the previous chapters, I delved into the antecedents of the debate on deception in everyday life and in medicine. After untangling the dense concepts of lying and deception by examining the works of philosophers and linguists, I settled on working definitions of both 'lying' and 'deception'. I then explored the

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* Although the Navajo belief that language shapes reality may at first sound strange to Western ears, Christakis has shown that many American doctors believe in the 'self-fulfilling prophecy', which bears close resemblances to the Navajo belief[11](p.135). The self-fulfilling prophecy is rooted in the idea that what the doctor says to the patient will shape the outcome of the disease.

philosophical arguments underpinning the tensions between absolutist and non-absolutist moral philosophers, and the tensions within non-absolutist positions. In chapter 4, I focused my attention on truth-telling and deception in the specific realm of medicine and medical ethics, scanning the meagre regulatory literature and contrasting this with the realities of clinical practice. I surveyed and discussed the arguments put forward by medical ethicists regarding the acceptability of deception in medicine, applied moral theories to the clinical context of medicine, and dwelled on the significance of trust in the doctor-patient relationship and on the links between trust and truth-telling. In this chapter, I moved away from theoretical concerns to focus on actual medical practice, examining some variations in attitudes and practices concerning truth-telling and deception in medicine across historical periods and cultures. In the next chapter, the methodological choices for the empirical component of the study will be explained and justified.

CHAPTER 6

Methodology – Combining Philosophical and Empirical Methods

Introduction

It is evident that the choice of research methods and methodological approach should depend on the nature of the problem to be examined. There is little point, for instance, in using in-depth qualitative interviews to discover the average age of a population. A questionnaire would be more suited to that end. It is therefore valuable at this point to recapitulate the aims of the thesis and to assess the ways in which empirical methods will help fulfil them.

In its crudest form, the thesis attempts to answer the following question: are doctors ever justified in lying to or deceiving their patients and, if so, what sorts of justifications might be given to support this position? As the previous chapters have shown, medical ethicists and moral philosophers have traditionally addressed this question by reference to the tension between deontological (duty-based) obligations to the patient and consequentialist moral reasoning, in which overall consequences are the overriding factors affecting the moral legitimacy of an act. Depending on the weight attributed to each of these philosophical positions, moral philosophers and medical ethicists have leaned either towards a full disclosure of information irrespective of the consequences, or a more deliberative policy of disclosure based on the likely consequences of the shared information.

The major problem with the arguments and their resulting normative conclusions is that they separate the problematic issue from its natural context, creating a sort of vacuum where the realities of the clinical setting and the actual views of the actors involved are conveniently absent. What is at the heart of the philosophical debate is indeed the apparent conflict between consequentialism and deontology, but the problem is oversimplified when displaced into a theoretical world devoid of contextual factors. These contextual factors must be acknowledged, assessed

and taken into account to arrive at solutions which are both philosophically sound and feasible in practice. An unnamed author wrote in an issue of the *Bulletin of Medical Ethics*:

> If medical ethics is to take and hold a central place in the practice of medicine, it is vital that it should build a body of empirical data to reduce its reliance on conjecture. Yet it remains rare to find contributions to such data in bioethics journals[193](p.16).

The interplay between empirical research and philosophical medical ethics

Although some modern philosophers and medical ethicists have addressed the issue of the moral acceptability of deception from a philosophical position, none (so far as I have been able to discover) have supported their claims by conducting empirical fieldwork[6 10 29 72 102 148 152 153 155 194]. This has led to sweeping assertions, for example that lies damage trust more than other forms of deception[6 72]. Bok also states that 'many lies to those who are very ill [...] are taken by the liars themselves as understood and accepted by all involved' without citing a single source of evidence[9](p.88). Jackson, commenting on Higgs's assertion that lying and non-lying deception are morally equivalent due to a shared intention to mislead, wrote: 'I do not think that this view *is* widely shared. It is not shared, at any rate, outside the medical context'[195]. Again, there is no supporting empirical evidence. Indeed, the findings of the present research suggest Jackson's hunch may be false (see chapter 8). Those few studies that have included empirical elements in their analysis of truth-telling do not examine the ethical aspects of their findings in any great detail[143 196-199].

Most moral philosophers stay well clear of the research methods of social scientists, and few social scientists have the training (or desire?) to conduct in-depth philosophical assessments of their findings. Søren Holm has described how descriptive ethics, which deals with the study of ethical attitudes, has traditionally been scorned by philosophers who compared it unfavourably with 'purer' branches of philosophy such as metaethics and normative ethics[200](p.23-24). Yet for a subject such as medical ethics, which partly aims to arrive at concrete recommendations for healthcare professionals, descriptive ethics is key to providing advice based on reality.

The long-standing neglect of descriptive ethics may be partially responsible for the gaps between what ethicists recommend and what actually happens at the coal face. Hoffmaster writes that 'taking medical ethics to be "applied" moral philosophy simply does not fit the experience of those who have spent time in clinical settings'[201](p.1424). Medical ethicists are more likely to offer practical guidance that will impact on the practice of medicine if they are aware of the realities of clinical practice and take these into account in formulating their advice.

It appears that bioethics, as a field of study, is becoming more sensitive to the potential contributions of empirical research. In the last twenty years, the number of bioethical articles incorporating an empirical component has increased considerably[202]. This has lead some commentators to talk of an 'empirical turn' in bioethics[203](p.50). Borry, Schotsmans and Dierickx attribute this change to three factors: 1) a dissatisfaction with the traditional theory-driven approach to bioethics (deemed too abstract, contextually insensitive and impractical), 2) the rise of the clinician-led, hospital-based discipline of clinical ethics, and 3) the emergence of evidence-based medicine (EBM), with its accompanying emphasis on basing health care decisions on sound empirical research.

Despite the proliferation of empirical bioethics papers, there remains 'an interdisciplinary debate' on the value of empirical research to ethics[204](p.1). To encourage the practical and theoretical development of empirical ethics, Borry, Schotsmans and Dierickx have called for a 'framework to give insight into the relationship between empirical data and ethical principles or theories, and a methodology, to allow the integration of empirical information in ethical reflection and decision-making'[203](p.71).

Empirical ethics, although widely used in the literature, refers to a range of views on the relationship between moral theory and empirical research. Molewijk *et al.* distinguish four traditional approaches to the use of empirical data in bioethical reasoning[205]:

1. The *prescriptive applied ethicists* view moral theory as the final arbiter of right and wrong. They adopt a top-down approach to morality, whereby a moral theory

is deductively applied in a particular context. On this view, empirical data cannot change the content of moral theory.

2. *Theorists* also view moral theory as the final arbiter, but concede that empirical data may refine moral theory, although only to a slight degree. Unlike prescriptive applied ethicists, theorists are concerned primarily with using empirical research to hone their moral theory, not with applying theory to concrete situations.

3. *Critical applied ethicists* assign moral credibility to both moral theory and empirical data, using moral principles to reflect on empirical data and data to reflect on principles. Empirical research can thus modify moral theory (by rejecting the validity of a particular empirical assumption, for example). Their model can be both deductive and inductive. To quote Molewijk *et al.*, 'in critical applied ethics studies there is a mutual interaction between empirical data and moral theory, while maintaining the fundamental distinction between the descriptive and the prescriptive sciences'[205](p.57).

4. *Particularists* believe that the location of morality resides in features of the specific context, rather than on rules or principles. For this reason, empirical data are central to the identification and explanation of right and wrong.

As the authors point out, all four models have been subject to criticism. Prescriptive applied ethicists and theorists, by relying so heavily on moral theory, are attacked by those who question the possibility or validity of a universally applicable moral theory. Their dismissive attitude towards the views and reasoning of moral agents also leave them open to accusations of paternalism. Particularists are accused of neglecting the 'critical voice of external criteria', such as moral theories or principles, and of a consequent moral relativist position[205](p.57). As for critical applied ethicists, the criticism is aimed at their putative inability to explain when moral theory should be adjusted to 'fit' the empirical data.

In light of the problems with the traditional models, the authors propose a fifth model: integrated empirical ethics (IEE). In essence, IEE considers the empirical and the normative as entwined and inseparable[205](p.57)[206](p.88). It rejects the traditional distinction between fact and value, arguing that 'facts' are themselves products of value-laden processes and that moral theories are ultimately based on empirical premises[207](p.269). Neither moral theory nor empirical data has prima facie moral authority. What is right or wrong is determined by a close examination of the situation, and 'mutual adjustments of both moral theory and the morality of a social practice'[203](p.59). In the absence of a pre-established moral theory as a starting point, it appears that IEE faces the daunting challenge of clarifying the nature of the mutual adjustments (e.g. with what are the 'facts' supposed to be adjusted?) and the precise role of context in generating normative conclusions.

Although Molewijk *et al.* recognise that IEE is still 'work in progress', it currently appears to be a confusing relativist blend of critical applied ethics and particularism[203](p.59). Indeed, some proponents of IEE use the methodology in discrepant ways[208 209]. In another paper, Molewijk himself writes: 'I quite often struggle with trying to explain my theoretical view on integrated empirical ethics and actually executing integrated empirical ethics myself'[209]. Since IEE's methodology gives scant guidance on how to systematically integrate moral theory and empirical data, I favour another model (figure 1 below) to illustrate the relationship between theory and data.

In Molewijk *et al.*'s taxonomy, the proposed model would fall within 'critical applied ethics', although I see no reason why it cannot also be reflexive, recognising that both empirical research and the process of reflective equilibrium are not value-free. The model ascribes initial credibility to both empirical data (including particular moral judgements) and bioethical principles and determines the normative weight of the data or principles using reflective equilibrium (see p.138). The proposed model, which highlights the synergistic relationship between empirical research and moral theory, differs in this way from Goldenberg's interpretation of evidence-based ethics, which views scientific or factual evidence as *determining*, rather than informing, right action[210].

While moral judgement will inevitably play a part in moral deliberation and adjustment decisions, critical applied ethicists can provide an adequate account of when to modify theory by appealing to a process of 'reflective equilibrium' with basic moral principles as a justificatory starting point (see p.138-140). Thus the proposed model is, in my view, more theoretically coherent and practically workable than current versions of IEE. The model nonetheless shares with IEE a deep appreciation of the contextual features of a situation and the potential value of empirical data to the development of moral theory.

As the above discussion demonstrates, the relationship between ethics and empirical research remains a highly contentious issue, linked in part to the deeper ontological question about moral relativism and moral universalism. While I am sceptical of moral relativism, the issue is not a central concern in the present thesis.

In an editorial on empirical ethics, Borry, Schotsmans and Dierickx describe a basic assumption of empirical ethics: 'Empirical ethics states that the study of people's actual moral beliefs, intuitions, behaviour and reasoning yields information that is meaningful for ethics and should be the starting point of ethics'[204](p.1). Although I wholly agree that an examination of people's views and reasoning can contribute to ethics, I do not believe it need be the *starting* point for ethics. Starting an ethical analysis with empirical data runs the risk of overlooking ethical issues neglected by participants. Similarly, reflecting on ethical issues *a priori* or based on assumed realities can lead to a myopic ethical examination which ignores important moral issues identified by the 'stakeholders'. In the proposed model, the starting point could either be the theoretical debate or the empirical data, as long as the researcher moves from one component to the other. Combining both components increases the likelihood of capturing the full ethical complexity of the subject matter.

The figure below shows how theoretical bioethics, empirical work and practical recommendations might interrelate.

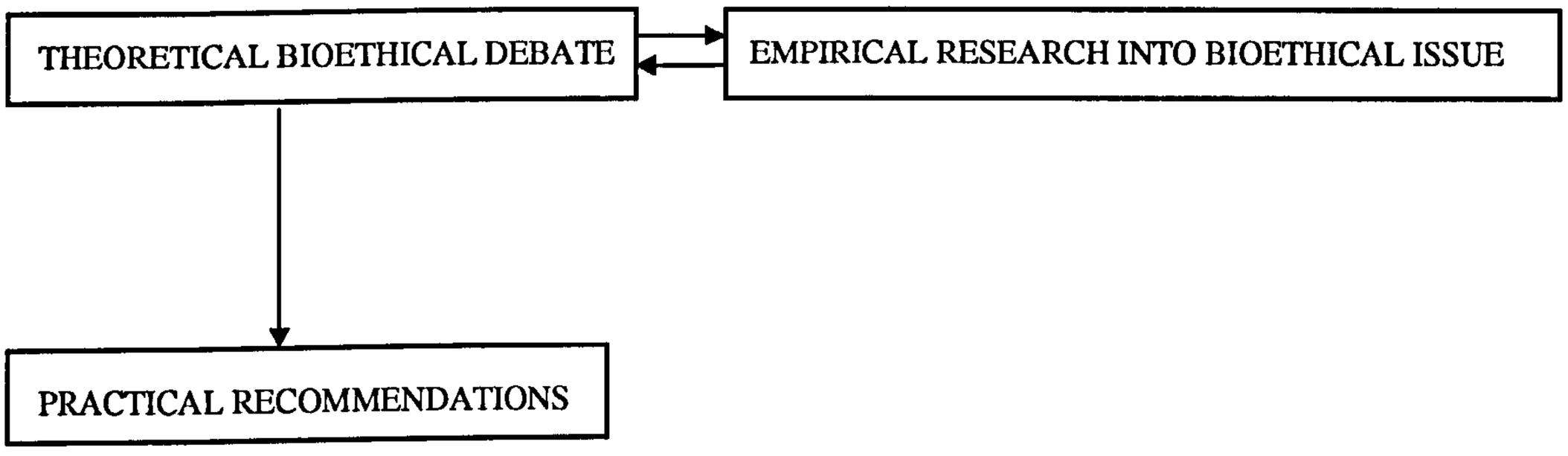


Figure 1a: diagram showing the interplay between philosophical bioethics and empirical research

Theoretical analysis can generate empirically testable questions whose answers will feedback to the theory. This *feedback cycle* continues, in a process of reflective equilibrium, until researchers are satisfied that the theoretical discussion is firmly grounded in empirical facts. Once this stage is reached, practical recommendations, now based on empirically informed bioethical reasoning, can be made.

There is another, less direct way in which empirical research can inform bioethics, which is to evaluate the effects of practical recommendations resulting from the theoretical analysis. For even if these recommendations are empirically informed, in practice there may well be overlooked, unforeseen or unpredictable factors influencing the outcomes of the recommendations. A fuller representation of the interplay between philosophical bioethics and empirical research would thus be:

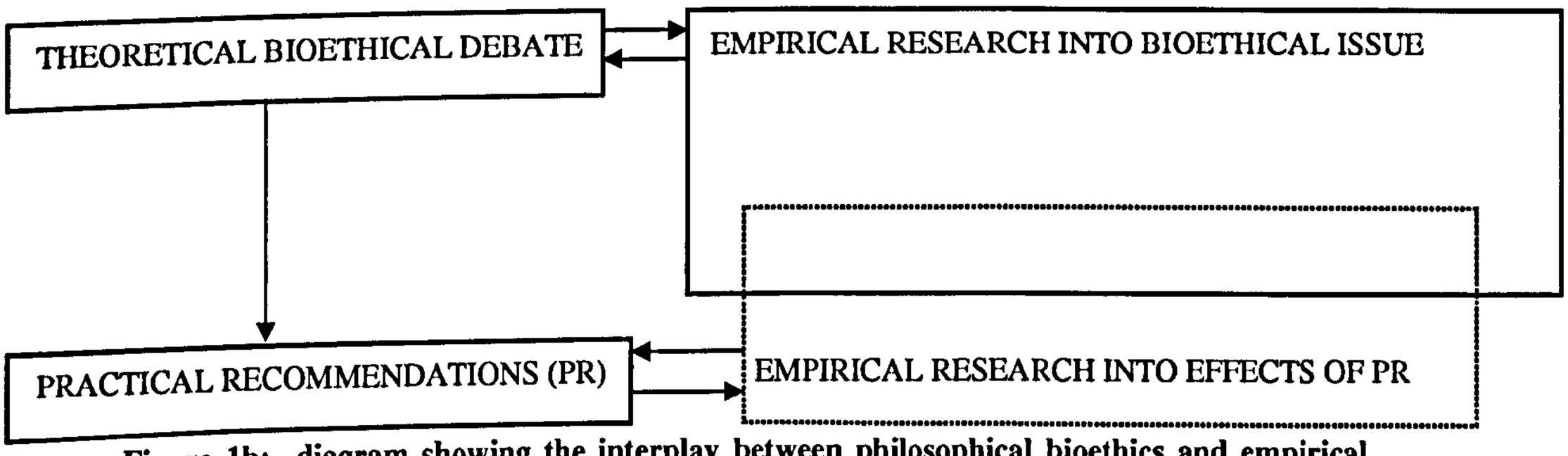


Figure 1b: diagram showing the interplay between philosophical bioethics and empirical research

The interlinked boxes on the right illustrate the fact that the research into the practical recommendations forms part of the empirical research into the bioethical issue.

I should make it clear that I am not claiming that ethics should simply be a matter of empirical research or that social practice and morality are equivalent. There is no smooth transition from 'is' to 'ought' and how we actually behave does not necessarily dictate how we ought to behave. Even the most cursory glance at some of the dishonourable episodes in mankind's history, where entire communities have acted in morally despicable ways, provides the basis for solid counterarguments to such claims. Finding out *what* people think about X and *why* they think this about X does not, *ipso facto*, tell us whether X is morally good or bad. These empirical facts have no normative force in themselves, unless one subscribes to forms of moral relativism that consider morality simply to be the attitudes and reasons of groups or, in the case of moral subjectivism, individuals. However, they can help us evaluate the validity of arguments which rely on claims concerning people's preferences and reasons[211]. Any philosophical argument based on erroneous factual assumptions can be rejected on those grounds alone, while those based on good empirical evidence are correspondingly strengthened.

As Holm writes, an ethicist who requires all doctors to obtain 'fully' informed consent from autonomous A&E patients is advocating something so unrealistic that no doctor will take him seriously[200](p.28). There is simply insufficient time in most A&E situations to spend precious minutes obtaining 'fully' informed consent. Such misplaced criticisms, however well-argued philosophically, do little to establish the credibility or usefulness of medical ethicists to medical practitioners. The ethicist would be 'playing with emptiness', as one Chinese saying goes.* An important function of empirical research in medical ethics is thus to root the theoretical concerns of medical ethics in the realities of the medical environment, and to better direct philosophical enquiries to matters of practical relevance by removing -- or reducing -- unnecessary speculation[212].

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* This Chinese phrase was cited in Hoffmaster, B.[201](p.1429).

Commenting on Bok's analysis of truth-telling, W. Peter Robinson remarks that although Bok examines the ethical issues of truth-telling, she makes no reference to empirical evidence on the preferences and moral judgements of those involved in decision-making[9 37]. As I mentioned in chapter 3, Bok highlights the potential consequences of benignly intended lies on the deceived, the liar himself, and the institution of promise keeping but her appeal to these consequentialist reasons is not supported by empirical evidence. This points to another use of empirical research in medical ethics: informing or rejecting ethical arguments which incorporate empirical claims (and consequentialist arguments by definition always do so).

Both Holm and Brody contend that, although empirical ethics can illuminate the validity of consequentialist arguments, it cannot assess the validity of non-consequentialist reasons[200 213]. Holm, for example, writes: 'We can investigate the harms caused by lying, but not whether lying degrades human dignity'[200](p.30).

Depending on the meaning of dignity, this last point is moot insofar as it rests on the assumption that human dignity does not depend on the beliefs or attitudes of individual agents.* Lying, in most cases, may infringe the dignity of the deceived but the connection need not be a logical one. A patient who autonomously asks his doctor to avoid disclosing a grim prognosis by any means necessary will probably not consider his dignity violated if the doctor then lies about a gloomy prognosis. On the contrary, he may see such a lie as respecting his dignity.

Now, one might adopt a substantive conception of dignity, which would deny that dignity is a subjective matter. Under such a conception, no amount of consent would be sufficient to 'dignify' an act since dignity transcends contractual agreement. The legitimating force of consent is constrained by other moral values. However, on a procedural conception of dignity which emphasizes the importance

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* 'Dignity' is another highly contentious term in bioethics. Häyry, for example, provides several interpretations of the concept, including a Kantian account (dignity is based on our rationality), a Catholic account (dignity comes from God), a genetic account (dignity is owed to everybody with human genes) and a utilitarian account (dignity is based on the ability to suffer)[214].

of fulfilling certain consent conditions, it is agents themselves, through autonomous, contractual agreement, who decide whether or not dignity is respected.* Under conceptions of dignity which value consent and self-respect, empirical work can provide clues on the extent of the correlation between lying and the degradation of human dignity, and may potentially offer counterarguments to the deontological claim that lying disrespects the deceived.

It is true, however, that some claims do not seem open to empirical support or refutation. Take Augustine's claim that lying goes against the 'appointed end' of language -- how can empirical work help in evaluating this assertion? Though we can ask people about the nature of the appointed end of language, their answers might not represent the 'true' appointed end. If the immorality of an act is intrinsic and not dependent on external factors, then no amount of empirical research will resolve the issue. Yet, even for absolutist deontologists, empirical research may be valuable in the pragmatic sense of examining the factors which encourage people to violate the forbidden rule[200](p.36). Efforts could then be made to prevent or reduce the violations by altering relevant factors.

A sound ethical analysis starts by gathering relevant facts. Some facts may be unobtainable, in which case the ethicist must make do with what is available. Many facts, however, can be discovered by asking the right people or looking in the right places. Empirical research in medical ethics can reveal facts that may be instrumental in the making of well-informed and accurate ethical analyses, at the beginning of the analytic process (by providing factually relevant information and unveiling ethically problematic issues), at the middle (by providing information on the likely or foreseeable consequences of an action, for instance), or at the end (by helping to select options that are most likely to work in practice). It can also be informative *after* a decision is implemented, assessing the outcome of the analysis and, if needed, recommending changes based on that outcome.

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* I owe this distinction between procedural and substantive conceptions of dignity to David Cummiskey, from his lecture *Sex, suicide and two conceptions of dignity*, March 30, 2002, Seattle, Washington, The American Philosophical Association Pacific Division[215].

Furthermore, in the face of options supported by equally good moral reasons, the data might sometimes provide an additional reason to choose one option over the other (an ethical 'tie-break'). If confronted with two equally morally acceptable options, it would be preferable to choose the option that most closely matches the views and reasoning of the groups that will be affected by the decision. In the field of medicine particularly, where doctors are often required to interpret what constitutes a patient's 'best interests', empirical work can elucidate the patient's conception of the good and help balance the harms and benefits involved in decision-making. Respecting the patient's conception of the good -- his beliefs, views and preferences -- usually forms part of what constitutes the patient's 'best interests'.

The relevance of empirical work to medical ethics depends on the methodological leanings of the ethicist. A consequentialist will (or should) find an empirical study which reveals the consequences of an act X supremely relevant to the ethical evaluation of the act. A deontologist, however, who might see act X as violating an important or even an absolute rule, is unlikely to attach the same level of importance to the study. For a pluralist, who believes that the consequences of an act are significant (although not the only important factor), the study would also be useful. In short, disputes about the relevance of empirical work to medical ethics can stem from differences in fundamental moral theory, but since all moral theories will have *some* place for consideration of consequences, all should acknowledge some degree of relevance to empirical investigation.*

Empirical ethics and truth-telling in medicine

Commentators have often given their views and opinions on the issue of truth-telling in medicine, but rarely have they backed these up with anything more than abstract arguments or personal anecdotes and recollections. Oken observed:

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* Even Kantian deontology attributes some importance to consequences. In a published interview, Korsgaard notes: 'I do not think that it is correct to say that Kantian agents do not care about or are not interested either in the consequences of their acts. It would be impossible even to formulate a maxim without attention to the intended consequences of an act.'[216](p.56-57). Freeman also writes that deontology is not 'oblivious to consequences'[217]. Under deontological approaches, the rightness of an action 'cannot *simply* be defined instrumentally, as what maximizes some (nonmoral) good'[217](p.391) (his emphasis).

'This is a curious situation in an area of so great importance'[8](p.1120). This thesis tries to fill, at least in part, this lacuna in the study of truth-telling and deception in medicine, and to point out areas for further research.

To reduce conjecture in my analysis of the issue, additional questions must be addressed to answer my initial query; questions whose answers will require empirical methods of inquiry. In order to answer the main research question ('are doctors ever justified in lying to or deceiving their patients and, if so, what sorts of justifications might be given to support this position?'), three additional questions can be usefully addressed:

1. Can doctors' deception bring about an improvement or prevent deterioration in patients' health?

2. What do doctors think about the ethics of deception in medical practice?

and

3. What do patients and the general public think about the lies and deception of doctors?

The answer to question 1, under a non-deontological framework, would be of great relevance to the ethical evaluation of doctors' deception in medicine. A study that conclusively showed that benignly intended deception under conditions X, Y and Z was invariably or even frequently beneficial to the patient's health would provide a prima facie justification for deceiving patients under X, Y and Z. Yet, so far as I have been able to discover, there have been no empirical studies investigating the effects of doctors' deception on patient health. The reason for this, I suspect, is that it would be methodologically difficult to conduct such a study. There would be so many variables (patients' medical condition, life history, personal values, emotional sensitivity, number and closeness of relatives, and so on) that it would be difficult to make reliable comparisons. We would also need a quantifiable measurement of 'health' to ascertain whether deception had improved, worsened or did not affect the patient's health. And with what would we compare the patient's post-deception health? A hypothetical state of health if the patient had been 'fully' informed? How would we construct this hypothetical state?

Finally, the study would be ethically highly contentious as it would require some patients to be deceived while others would be informed. Warning prospective participants in the study that they may be deceived during the course of their treatment may be methodologically undesirable as it would potentially affect the success of the deception. The empirical part of this thesis gives some indication of the potential benefits of deception through first-hand accounts by doctors and patients. The results, however, are not statistically valid -- the empirical study is qualitative, not quantitative -- and so should be interpreted with caution.

There are several reasons to include questions 2 and 3. The first relates to one aim of the thesis: to provide a set of suggestions which will help improve current practice. A good way to achieve this is to ask doctors, patients and members of the public what their views are on the issue of deception in medicine, what their reasons are for holding these views, and on the basis of this information to arrive at a set of suggestions likely to satisfy most members of each of those groups. The research thus went beyond descriptive ethics, which is concerned with elucidating the *attitudes* of moral agents, to encompass the broader field of empirical ethics, which also incorporates the moral psychology (especially the moral reasoning) of moral agents.

Method in philosophical medical ethics

To shed light on the ethically relevant aspects of the problem, moral philosophers often start their analysis by breaking up the problem into component parts. In most cases, philosophers agree on what these relevant aspects are. Once this is done, however, chasms begin to form between the different clans of philosophers, depending on their chosen moral theory. A utilitarian will attribute greater weight to outcome components than a Kantian deontologist or a neo-Aristotelian virtue theorist. The balancing process between moral considerations, in short, can vary from philosopher to philosopher. It is important to distinguish, however, the two parts of the process: 1) the dissection of the ethical problem into component parts and 2) the balancing or other prioritization of the parts to arrive at a decision.

Whatever the ethical basis used as the starting point, philosophers tend to share the desire to persuasively argue their case. To achieve this goal, philosophers aim to put forward sound arguments, rooted in reason. A poorly reasoned argument, whatever the underlying ethical theory, will fail to convince logically-minded philosophers and be dismissed as shabby philosophy. Furthermore, despite the diversity of philosophical approaches, each approach will presumably accept the requirement that 'the factual assumptions underlying moral reasoning must be reasonably supported by empirical evidence and observation'[218](p.42).

Research in philosophical medical ethics tends to be a two-step process. As noted above, the researcher first identifies the ethically relevant elements of the moral problem at hand. In medical ethics, one such way of doing this is to use the 'four principles': beneficence, non-maleficence, respect for autonomy, and justice. Under this 'principlist' approach, a case will be scanned for issues falling under each of the principles. Thus, if a patient in urgent need of treatment arrives by ambulance following a horrific accident and is unable to give informed consent, the 'principlist' would invoke the principles of beneficence and respect for autonomy. In the current climate, the former principle (beneficence) generally trumps the latter in such circumstances on the basis that a 'reasonable' person would want to be treated in the event of serious injury.

The principlist may need to reflect on the principle of justice if there are many such patients or, alternatively, if the treatment is so costly that it is likely to deprive others of medical care. Non-maleficence may play a part in the ethical calculus if, for example, the treatment is likely to be more harmful than non-treatment. Although the principles may be of limited use in the second part of the two-step process, they greatly facilitate the 'opening up' of a case into its constituent parts.

The second -- and usually more difficult -- step requires carefully "weighing up" (or evaluating) the various elements collected in the first step, arriving at a well-reasoned choice and justifying that decision. The process of justification is essential to a sound philosophical argument, and can be viewed as a method of

ethical analysis in itself. In the bioethical literature, three main types of justificatory models exist.*

The top-down models

The top-down model starts with a fundamental moral theory (such as utilitarianism) and usually derives mid-level principles or rules which can be applied to specific circumstances. The model moves from a pre-selected ethical theory to particular cases. Consider the following deductive form premised on the hypothetical rule 'always disclose a diagnosis':

1. A doctor should always disclose the diagnosis to a patient with condition *p*
2. The doctor's patient is suffering from condition *p*

Therefore:

3. The doctor should tell the patient that he is suffering from condition *p*

The advantage of the model is obvious: it is logically valid. As in all properly formed (or 'valid') deductive arguments, if the premises are true, then the conclusion *must* be true. The major problem, of course, is that the first premise is not evidently true. The rule 'always disclose a diagnosis' is simplistic and fails to capture the full complexity of the issue of truth-telling. It requires further specification or 'filling in' to move from the abstract to the concrete.

To briefly illustrate the process of specification, imagine a doctor who illegally buys a kidney off a hapless, non-English speaking Bangladeshi teenager to transplant it into his patient. When questioned, the doctor justifies his act by invoking the principle of beneficence which, in its naked form, requires the doctor to provide net benefit to his patient. But here the doctor can be criticized for failing to specify the principle. In light of such a case, the principle can be expanded as 'the obligation to provide net benefit to a patient *using means that are both legally and morally permissible.*' As Beauchamp and Childress note: 'the abstract rules and principles in moral theories are extensively indeterminate;

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* For a more detailed examination of philosophical methods in medical ethics, see DeGrazia, D. and Beauchamp, T.[218]

that is, the content of these rules and principles is too abstract to determine the acts that we should perform'[72](p.387). Thus one danger with deductive forms is that the rules used as premises may be insufficiently specified.

Furthermore, the ethical basis for the entire model may be questioned. Why should, say, utilitarianism provide the basis for the rules and not a form of deontology? As there is no agreement on which normative moral theory to adopt, the top-down model can be criticized as fundamentally misguided by those with a different starting point.

The bottom-up models

Unlike the top-down models, which base their rules on overarching ethical theories, the bottom-up models start by examining particular cases before deriving rules induced from relevant features of the cases. Since the rules are generated by the particular cases, they will usually be less abstract than those of the top-down models. Instead, they will reflect the medical and social realities of the cases, taking into account the many factors that impinge on the moral evaluation of the event. On this approach, rules and principles are not pre-existing but are derived from concrete situations. Beauchamp and Childress describe inductivists as those who use:

> [...] existing social agreements and practices, insight-producing novel cases, and comparative case analysis as the initial starting points from which to make decisions in particular cases and to generalize to norms[72](p.391-392).

Some versions of casuistry are an example of a largely bottom-up account which stresses the importance of specific cases in the elucidation of moral problems. Arras writes:

> [...] the defenders of casuistry advocate an approach that works from the 'bottom-up', starting with our responses to concrete cases and then proceeding, as desirable or necessary, to the development of more abstract principles of moral rules[219](p.106).*

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* This does not mean that all casuists reject moral rules or principles as a source of guidance. As Arras notes, casuists disagree over the normative status of principles in ethical deliberation [219](p.109).

A casuist will attempt to find the best solution by comparing the features of a particular case with those of previous cases whose moral problems have been satisfactorily dealt with. The advantage of this model is that it bypasses the need for an agreed fundamental moral theory while allowing progress to be made. Furthermore, the inductive process guarantees the formation of moral rules in accord with common morality. The 'ought' will imply the 'can'.

One problem, however, relates to the choice of particular (or 'paradigm') cases to 'apply' to the problem at hand. With sufficient ingenuity, casuistry can be used to 'justify' the casuist's preferred decision whatever it might be. As Bedau writes:

> For three centuries casuistry has had a bad odor about it, because it seemed to its critics all too plainly to be a cynical and sophistical strategy to permit one to do whatever one wanted to do[87](p.vii).

However, in recent times, casuistry has found new favours as an approach to resolving conflicts of principles[72](p.393).

Coherence theory (or 'reflective equilibrium')

This third model attempts to reconcile the deficiencies of the top-down and bottom-up approaches by moving in both directions. It relies on the mutual adjustment between intuitions, confidently held moral beliefs, moral rules, and broader moral principles and theory[72](p.398). Van Delden and van Thiel characterise reflective equilibrium as a 'dialogue [...] going back and forth between information stemming from practice (morally relevant facts and moral intuitions [...]) and from theory (principles and background theories)'[18](p.254). The method may be depicted as follows:*

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* The method depicted is that of *narrow* reflective equilibrium. In the *broad* type, the aim is not only to cohere moral intuitions and principles with each other but with broader background theories (such as theories of justice, rationality, human psychology, and so on).

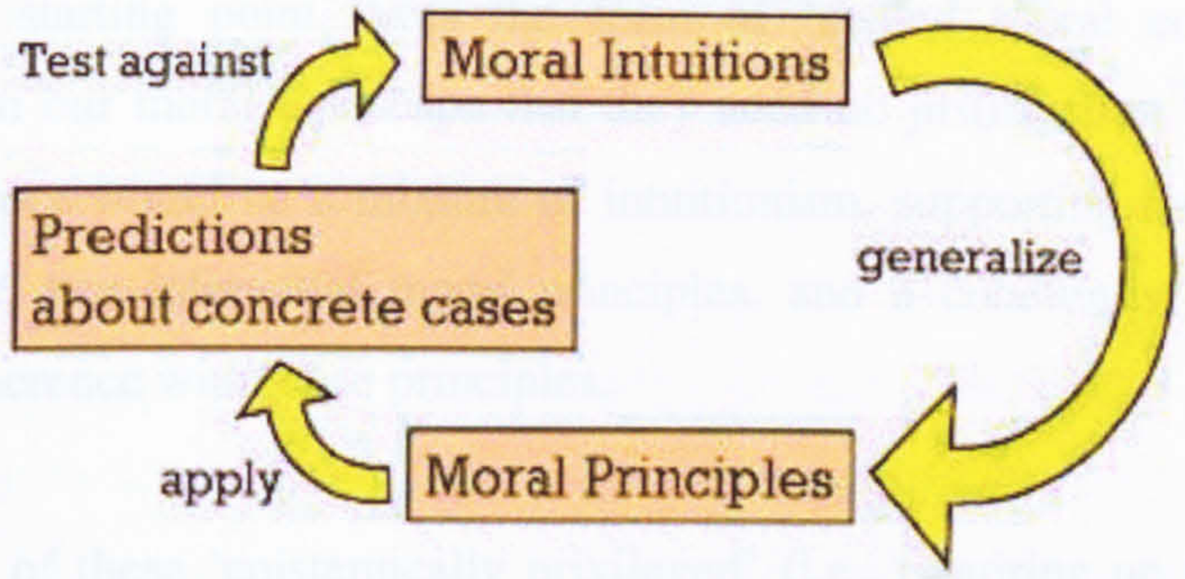


Figure 2: diagram showing the method of reflective equilibrium in ethics. Reprinted with permission from Lau, J. and Chan, J.[220]

So, for example, our intuition that stealing from the Oxfam collection box is wrong may be based on the wider principle that stealing, in most circumstances, is wrong. In order to be coherent, the derived moral rules or principles must fit with our intuitions and, equally important, must not clash significantly with other accepted rules or principles generated from other intuitions. Of course, some level of conflict will at times be unavoidable, but there comes a point at which conflict raises so many 'inconsistency' flags that something needs to be modified to accommodate the new belief.

The apparatus we use for our moral evaluations is therefore constantly in motion, always changing in response to new cases, even if only in the intensity of our convictions. The unreachable paragon of the coherence model is a perfect state of equilibrium where our intuitions, moral rules, principles and theory coexist in perfect harmony.

A problem with this model is that our intuitions and moral rules may all be wrong. We would, in such a case, be coherently wrong. We can easily imagine Hitler possessing a coherent, but nonetheless abhorrent, set of beliefs. Internal coherence cannot, in itself, be sufficient to validate the epistemic truth of our beliefs[18 221]. It simply tells us that our beliefs are consistent with each other, not that they are true. To overcome this undesirable conclusion, we require an agreed starting point from which to build our web of coherent judgements. This is where my preferred account deviates from a strong coherentist epistemology. Whereas the latter claims that beliefs are justified only in so far as they cohere with other

beliefs, my starting point takes the form of 'settled moral convictions' so entrenched in our moral landscape that they need no justification[72](p.400). The resulting theory would be a mixture of intuitionism, supporting the existence of certain basic, non-inferential moral principles, and a coherentist moral theory based on coherence with those principles.

The validity of these 'epistemically privileged' (i.e., requiring no further proof) and widely accepted basic principles would reduce the likelihood of a coherently immoral theory, while reflective equilibrium would provide a justificatory basis for our moral judgements.* As Shogenji writes 'coherence *with truth* is truth conducive on the level of individual belief, but coherence per se is not'[222](p.345) (his emphasis). This model is compatible with the four principles approach of Beauchamp and Childress[72].

Coherence theory does suffer from a certain vagueness, in particular about the exact way in which congruence is achieved, but it does provide a more moderate view than the two models examined earlier.† Although I earlier argued that empirical research is in many ways relevant to philosophical medical ethics, the precise nature of the interplay between the ethical and empirical components in this project was hard to predict in advance. Under coherence theory, each component adopts a critical attitude to the other. The nebulous nature of the theory, which mixes inductive and deductive approaches, and the interplay between norms, rules, principles and intuitions also seem to reflect the everyday moral reasoning of ordinary persons, although this is hard to prove empirically. Furthermore, the theory fits in well with the goals of this thesis, which attempts to reconcile normative judgements with the views and reasoning of the various stakeholders while acknowledging the realities of clinical practice.

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* I have adopted the phrase 'epistemically privileged' from Sayre-McCord, G.[221]

† Haslett, for example, criticizes Rawlsian reflective equilibrium for its inherent circularity and lack of guidelines for making 'adjustment decisions' to achieve the desired coherence[223].

Parallels between coherence theory and Grounded Theory

The coherence theory approach also goes hand in hand with the Grounded Theory (GT)-inspired approach employed in this thesis. GT methodology, in brief, constructs a theory based -- or 'grounded' -- on the close analysis of empirical data. It relies on deriving order, or coherence, from the data to construct a stable theory which can account for new and existing data. The resulting analysis, which aims to provide an explanatory framework for the beliefs and reasoning of the stakeholders regarding deception, can then be compared with the existing normative rules of the bioethical literature. Depending on the findings, the normative rules may be modified by reflective equilibrium to better reflect the considered judgements of the stakeholders.

Critical bioethics

D.D. Raphael considers philosophical debate as practically useful not because it can tell us how to live but rather in the negative sense of rejecting poorly argued conclusions:

> Philosophical debate can reach a firm negative conclusion that one particular set of beliefs should be rejected because it is internally inconsistent or because it rests on a factual assumption which is false[224](p.9).

Whether or not we accept this rather pessimistic view of the practicality of philosophy, Raphael stresses the importance of possessing correct factual information. If the empirical basis on which we lay our philosophical arguments is wrong, the whole edifice is unstable. This supports the need for what Hedgecoe, a health sociologist, has called a 'critical bioethics'[225 226].

The 'critical bioethics' approach aims to improve bioethical thinking by combining the strengths and insights of philosophical bioethics and social science research[226]. The product of the amalgam should be a form of bioethics, grounded on empirical work, which questions its own assumptions and which is generally much more self-critical. Critical bioethics, Hedgecoe writes, 'tests its theories in

the light of empirical experience, and *changes them as a result*'[226](p.137) (his emphasis).

Hedgecoe lists four characteristics of 'critical bioethics':

1. *Empirically rooted*

The issues of concern to bioethics should be derived from empirical research, 'looking at a particular setting (e.g., the clinic), talking to participants and taking note of what they say'[226](p.135-136). Hence, when examining the ethics of a technology, the 'first port of call should be the social science literature about that technology, rather than the standard bioethics debates'[226](p.136). Critical bioethics is thus a 'bottom-up' approach to ethics.

2. *Theory challenging*

The findings from the empirical research should be incorporated into the analyst's theoretical framework. Empirical data which clash with the chosen ethical theory should not be dismissed, but should prompt the analyst to modify or, indeed, dismiss the ethical theory in favour of one that more closely matches the findings.

3. *Reflexive*

Reflexivity requires the analyst to acknowledge his personal context, and to appreciate how his background, beliefs and values impinge on his approaches to moral issues. This self-awareness, Hedgecoe argues, 'does not mean that we cannot say anything meaningful about other people's lives or about their choices. It makes us think about how bioethics came to occupy the position it does in medical settings and education, and raises issues of power and authority that we would perhaps, rather not think about'[226](p.140).

4. *Politely sceptical*

Critical bioethics should question the claims of both bioethicists and those respondents who provide the empirical data (in our case, doctors, patients and members of the public). The 'polite' means not that open confrontation is necessary, but that 'the truth is often more complex than people claim'[226](p.140).

The primary advantage of a 'critical bioethics' over the more traditional, philosophy-dominated forms of bioethics is that it will reduce the chasm between theory and practice mentioned earlier in the chapter. As a result of its concern with the realities of medical practice in establishing satisfactory theories or guidelines, critical bioethics is more likely to appeal to those most affected by the issues, such as patients and healthcare professionals.

The choice of qualitative methodology

In their later study on doctors' deception, Novack *et al.* call for more empirical research on deception. 'It would be useful', the authors write, 'to interview physicians to more fully understand the subtleties of their decision making'[22](p.2985). Interviews are indeed suited to the elucidation of reasons for beliefs and actions, primarily because they allow respondents to express themselves freely, without the constraint of predetermined categories, and present opportunities for the interviewer to probe the respondent further on points of particular interest. Gordon and Daugherty used semi-structured interviews to discover oncologists' attitudes to disclosing a terminal prognosis[143].* Holm also settled on semi-structured interviews as his preferred method of data collection in his study[200](p.79).

Like Holm, I confined myself to qualitative methods. Although such methods have been widely used in history, anthropology and medical sociology for several decades, it is only in the last ten years or so that qualitative methodology has impacted healthcare research[228]. The many articles on qualitative methods published since the mid 1990s in the British Medical Journal alone reflect the growing belief that such research can contribute meaningfully to medicine, gradually replacing the old view of qualitative research as subjective, unrigorous, unsystematic and thus unscientific[229-237].

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* In semi-structured interviews, the researcher usually follows an interview schedule but can vary the order of the questions and ask further questions depending on the interviewee's answers[227](p.110).

Qualitative research allows us to explore people's beliefs and attitudes about particular events or phenomena (e.g., why people start or stop smoking), to gain a deeper understanding of how certain states of affairs come about (e.g., why a doctor decided to deceive a patient in a specific context), and to obtain data for use in future research, including quantitative investigations[230 232 238]. To demonstrate the potential value of qualitative work to quantitative studies, Pope and Mays refer to an interview-based study on sexual attitudes which revealed popular misunderstandings surrounding terms such as 'oral sex', 'penetrative sex' and 'vaginal sex' and which subsequently informed the drafting of a large questionnaire study[239]. In 2001, Barbour commented: 'In medical research the question is no longer whether qualitative methods are valuable but how can rigour be ensured or enhanced'[235](p.1115). In this research, I start from the position that qualitative research, though necessarily interpretative, can be sufficiently critical and systematic to generate valid forms of evidence.

The choice of a qualitative approach was in part due to the nature of the research questions, which were concerned more with eliciting the range and nature of underlying reasons for allowing or condemning deception than with discovering the statistical prevalence of people's views on the issue. As few studies have clearly delineated the rationales for people's positions vis-à-vis deception or the range of possible justifications for these positions, a qualitative approach was more likely to allow the emergence of a range of previously empirically unexplored concepts and themes than a quantitative approach.

It might be useful to make explicit the research questions which, through the use of qualitative empirical methods, could shed light on the moral acceptability of benignly intended deception in medicine and the distinctions between different forms of deception. Once the research questions were made clear, the choice of methods and methodology that would best suit the questions also became evident. The main research questions were:

1) What do respondents understand by 'deception'?

2) Do respondents hold absolutist or non-absolutist views regarding the moral permissibility of deception?

3) Do respondents from the various groups differ in their evaluation of the desirability of benignly intended deception in medicine?

4) What kind of reasons do respondents give to justify their views on doctors' deception? How do the reasons relate to the justifications given in the philosophical and medical ethics literature?

5) Do respondents draw moral distinctions between various forms of deception? How do the distinctions relate to arguments in the philosophical literature on deception?

The open-ended nature of qualitative interviews and focus groups seemed well suited to address many of the questions listed above. A qualitative approach fitted the heavy emphasis on understanding the *reasoning* of respondents better than a quantitative approach, which would have been ill-suited to capture nuances in respondents' justifications. The respondents' personal experiences of deception in medicine could also be extracted in much richer detail using qualitative methods which allow the respondents' narrative to flow. The 'explorative flexibility' of certain qualitative methods, such as interviews and focus groups, and the possibility of asking respondents for explanations and clarifications about interesting or imprecise answers provided strong reasons to opt for a qualitative approach[240].

Another reason behind the selection of a qualitative approach was the theoretical parallels between qualitative methods and inductive methods in bioethics. The theoretical underpinnings of inductive qualitative research fit nicely with the coherence theoretical approaches widely used in medical ethics. Grounded Theory (GT), on which my empirical methodology was based, bears a close theoretical resemblance to coherence theory. Both methodologies rely on an iterative interplay between data and theory. Both combine inductive and deductive approaches and shun rigid rules in favour of flexible interpretation. These common principles suggest that combining inductive philosophical approaches and qualitative methods makes good methodological sense. This project, I hasten to add, was amongst other things an *exploration* of how different empirical, qualitative methods might be applied in the context of medical ethics. This exploratory purpose explains, in part, the eclectic choice of methods.

To recap, the project combines two distinct methodologies: 1) an argument-based, philosophical methodology, and 2) an empirical approach informed by Grounded Theory approaches. Indeed, one could include a *third* methodology, based on the method of reflective equilibrium (coherence theory) which aimed to regulate the interplay between the empirical and philosophical approaches. The diagram below indicates the relationship between these three methodologies. The double-ended arrow represents the process of 'reflective equilibrium'.

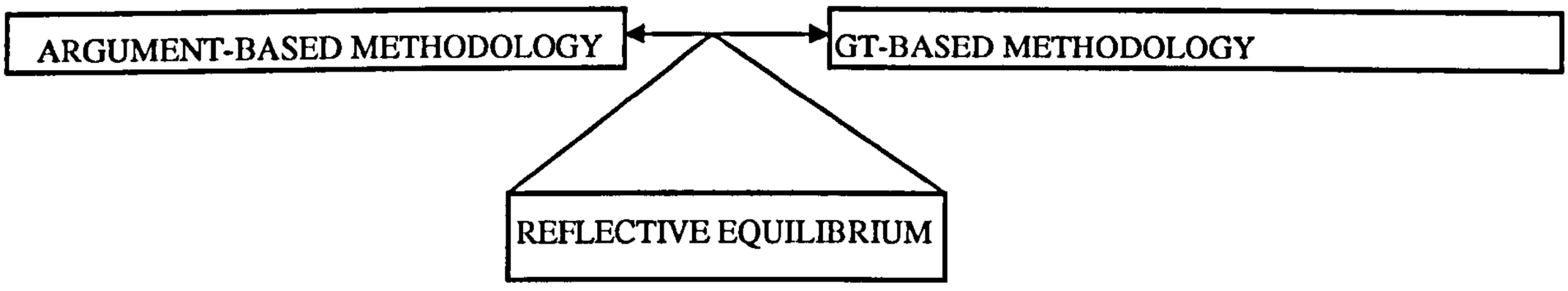


Figure 3: diagram showing the relationship between the three methodologies used in the present research: 1. argument-based, philosophical methodology 2. Grounded Theory-based methodology 3. reflective equilibrium

Selection of research methods

There exists, within the qualitative palette, a broad range of possible methods: participant and covert observation, several types of qualitative interviews and questionnaires, and focus groups, amongst others. Prior to a definitive decision on the choice of methods, I conducted pilot studies, using the selected methods, to assess the usefulness and appropriateness of the methods. The pilot studies also provided opportunities for participants to comment on the content and format of the methods and thus to refine the methods used.

Participant observation

As Holm suggested in his study on the ethical reasoning of Danish doctors, probably the best way to uncover the reasoning of doctors and patients would be to covertly observe the interaction of both parties in the clinical context and then to directly interview them at length in order to discern the intricacies of their moral reasoning[200](p.77). This method would allow the researcher to assess the

frequency and nature of deceptive practices in context, to compare stakeholders' accounts of what happened with the researcher's observations, and to unearth the views and reasons of the relevant parties soon after the 'incident' had occurred. Furthermore, covert observation would avoid, or greatly reduce, the epistemic concerns regarding the accuracy of the respondents' statements[227](p.161-162). Even with honest intentions, absent-mindedness, self-deception and other reasons can lead some respondents to give answers that do not accurately reflect reality.

It was clear, however, that such an approach was impracticable. Not only would it have required a detailed knowledge of medicine (to initially identify these 'incidents') but it would probably have failed to satisfy the requirements of even the most casual of research ethics committees in the United Kingdom. The covert observation method by definition operates without the consent of those observed, and the interrogation of patients about potentially sensitive matters adds another ethical difficulty to the method. The requirement of medical expertise and the ethically contentious nature of the method ruled out both covert and overt participant observation.

Focus groups

Focus group methodology consists of gathering groups of people together to discuss a topic of interest[227](p.337). Unlike individual interviews, focus groups allow the participants to interact with each other, thereby allowing a flowing exchange of ideas and information. Typically, the participants will agree or disagree about certain issues and clarify their views for the sake of other participants. This interactive process provides an insight into the beliefs and attitudes of participants, as well as broader group norms and cultural values[241]. The researcher is thus able to obtain detailed data from many subjects within a short time span. The flexibility of the format allows the researcher to explore new ideas or to request further detail about an issue raised by the participants.

Holm, in his study on the ethical reasoning of doctors and nurses, dismissed focus groups as a possible method, pointing out that 'there are no extant studies using this approach to study ethical reasoning'[200](p.78). Although this may be true,

focus groups have been used extensively to examine people's experiences and understanding of illness and disease[242]. Kerr *et al.*, for example, have used the focus group method to examine the views of laypersons on genetic research[243]. The authors, who conducted a total of 10 focus groups, justified their choice of method by arguing that focus groups provide

> [...] an insight into the negotiations in people's accounts of their attitudes, beliefs, and values, and because the techniques of brainstorming and focusing on particular topics or vignettes allows for the articulation of a breadth of views as well as detailed exploration of relevant issues[243](p.44).

Gordon and Daugherty also conducted a focus group with six oncologists in their study[143](p.151). The authors then used the data gathered from the focus group to refine their interview schedule. On reviewing the methodological options, I decided not to dismiss such a potentially useful tool. The mere lack of application does not signify that focus groups are inappropriate, but may instead reflect the paucity of studies on ethical reasoning and researchers' preferences on method. On the contrary, the very open and interactive nature of focus groups lends itself well to the access and elucidation of underlying reasons for participants' beliefs.

Despite the recent emphasis on respecting patient autonomy, there is still, arguably, a power differential between doctors and their patients. This differential is partly based on the disparity in medical knowledge between doctor and patient and the potential of this medical knowledge to affect the life and well-being of the patient. In such situations, where participant groups vary in their levels of influence, focus groups allow members of each group to share and express their feelings and opinions with others in a similar position. Being surrounded by peers is likely to encourage participants to freely divulge their views on deception in medicine.

Focus groups also highlight deviant cases and allow other participants to respond and challenge the deviant case. The reaction of these participants facilitates and enriches the all-important deviant case analysis necessary for the production of an overall theory capable of accounting for both common and rare cases[242 244]. Just as focus groups can show disagreement, they can also indicate the level of agreement in a group, as long as the members feel sufficiently at ease to express

dissenting views. The level of consensus or divergence in the focus groups may be compared and contrasted with the results of the questionnaire.

Piloting

The focus group method was piloted on four final year medical students from the University of Oxford Medical School. The pilot study made clear that focus groups, especially if using concrete cases or scenarios to generate debate, could be a fruitful and time-effective method of data collection. As a result of the pilot focus group, I decided to use scenarios in the actual study to provide greater focus to the discussion. A similar approach, using a mixture of general questions and vignettes, was used by Kerr *et al.*[243].

The fact that all the respondents knew the researcher as well as each other in the pilot may explain their willingness to divulge even sensitive information regarding their own cases of deception. Both McLafferty and Kerr *et al.* write that, in their experience, groups comprised of members who already know each other are more likely to speak freely about sensitive and complex topics than groups composed of strangers[243 245]. One of the limitations of focus groups is that group members, to avoid offence or for other reasons, sometimes abstain from raising objections or even agree with the views or comments of their fellow members, although they would disagree in private[227](p.349). This is no doubt more likely to happen among strangers, but it highlights the need to be cautious when interpreting results and to introduce the focus group in ways that will foster debate and encourage participants to engage in the issues.

Another downside of the focus group method was discovered when transcribing the material: unlike interviews, where the one to one nature of the interaction has a simple turn-taking pattern (i.e., person A speaks, then person B, then A, and so on), the participants in a focus group often talk simultaneously rendering the transcription process both difficult and extremely time-consuming.

Questionnaires

At the exploratory stage of the project, I examined various possible research methods. An obvious tool was a questionnaire presenting a series of ethically problematic scenarios allegedly solvable through deception. This method was successfully used by Novack *et al.* in their study of doctors' attitude towards using deception in medicine[22]. As Novack's study examined the separate issue of doctors' lying *for* patients (e.g., to insurance companies) and not *to* patients, the questionnaire was modified (with permission) to present cases more pertinent to the project. The project deals specifically with cases of deception considered morally problematic and does not concern itself with obviously objectionable cases of deception. Also, I have chosen not to address the ethics of using deception on patients with clearly 'reduced' autonomy, such as children or patients with severe learning disabilities. This is a complex and fascinating area but one which, ultimately, is distinct from the present project. It would require a separate thesis altogether.

To increase the chances of a high response rate, efforts were made to minimize the length of the questionnaire. Informal discussions with hospital doctors and GPs revealed that doctors are often asked by academic and non-academic researchers to partake in studies and complete questionnaires. Some researchers even offer payments or small gifts. In light of this anecdotal information and my own lack of funding for material incentives, limiting the completion time of the questionnaire to less than 30 minutes was of the utmost importance. Piloting showed that respondents took between 15-25 minutes to complete the questionnaire. Yet, despite its brevity, some respondents commented that the questionnaire was demanding and 'hard work' due to the sensitive nature of the questions and subject matter. The majority of the respondents were asked to ponder on situations and questions which they had never considered previously. This provided another reason to keep the questionnaire as short as possible, as I expected the attention of respondents to wane with time ('respondent fatigue')[227](p.129). In total, 229 questionnaires were collected and analysed.

Although not statistically powerful enough to allow generalizations, the questionnaire captured differences between respondents numerically, facilitating the process of comparison between groups. The questionnaire provided a *broad indication* of the variations between respondents. It also allowed respondents to rank certain reasons for or against deception (or disclosure) in order of importance. This gave some indication of the weight and popularity of certain justifications which would have been difficult to capture in interviews or focus groups.

Case 1	Doctor discovers non-paternity following blood test to ascertain compatibility between 18-year-old kidney donor and 'father'.
Case 2	Young patient, a keen climber, about to undergo a life-saving operation asks doctor if he will be able to walk after the operation. Doctor knows chances are extremely slim.
Case 3	Doctor inadvertently administers wrong dose to patient, but with no lasting medical consequences. Patient asks if all is well.
Case 4	Doctor inadvertently administers fatal dose to patient, who asks if everything is normal.
Case 5	Doctor puts financially poor patient on heart transplant waiting list, with expected 9-month wait. The patient has a 40% chance of dying while on waiting list.
Case 6	Doctors discover curable form of cancer on cancerophobic patient recovering from heart attack.
Case 7	Young mother of two is very hopeful that cancer treatment will work and asks doctor about survival prospects, which are poor.

Table 2: short description of cases included in survey

Hypothetical case scenarios

Table 2 above provides a brief account of each of the seven scenarios in the questionnaire.*

The scenarios cover a wide range of situations where benignly intended deception is a realistic option. They were constructed in consultation with clinicians, and in such a way as to incorporate conflicting moral obligations or duties, such as between being honest (principle of honesty) and doing what is beneficial (principle of beneficence) or avoiding doing harm (non-maleficence). The hypothetical scenarios are best thought of as 'thought experiments' designed to

* A copy of the questionnaire is appended in appendix C (p.313).

allow us to discern morally pertinent factors in assessing the acceptability or otherwise of deception in a variety of possible situations. Comparisons between two scenarios can also reveal elements of the respondents' ethical reasoning. In the questionnaire, for example, two of the scenarios (cases 3 and 4) differ in only one respect. The first depicts a doctor giving a wrong dose of medication to an elderly lady which causes nothing but mild and temporary discomfort. The second is identical except that the mistake has lethal consequences. In both cases, the patient is lucid and asks the doctor directly if everything is all right. It would be correct to assume, then, that any discrepancy in respondent attitude between the two cases will be based solely on an evaluation of the likely consequences of the act in question. Comparing and contrasting cases can pinpoint morally relevant factors.

The use of hypothetical scenarios serves two purposes. Since questions such as 'do you think doctors should ever deceive their patients?' or 'what do you understand by deception?' are so broad and, in some cases, abstract, respondents may find them both daunting and difficult to answer. Scenarios, by presenting specific cases, provide a greater focus to the research. Through the creation of scenarios, the researcher can examine particular instances or aspects of deception, and allow the respondents to base their answers on concrete examples. Instead of asking respondents for their definition of deception, for example, the researcher can ask whether they consider the doctor's behaviour or assertion, in a number of given situations, to be deception. The researcher, by manipulating certain details in the scenarios and examining the responses, can isolate factors that may be ethically relevant[246].

In their comments on the initial ethics committee application, the Research Ethics Committee expressed concern on the usefulness and reliability of hypothetical answers to hypothetical situations. The questions were *not* intended to discover what the respondents would actually do in real life (there might well be significant differences between people's responses to hypothetical questions and their behaviour in the equivalent life situations). The questions were intended to elicit what the respondents actually think -- at the time of their response -- about the moral issues raised by the questions.

Secondly, scenarios permit direct comparisons between groups. The wording of the questionnaire was kept almost identical from group to group, although minor modifications were made to reflect the perspectival differences between doctors on the one hand, and patients and members of the public on the other. By maintaining a constancy of form and content between the groups, I hoped to reduce the possibility of interfering factors which may have biased the researcher or respondent. These can be linguistic -- a single adjective can alter one's perception of a case or an act -- or related to variations in the flow or content of the questionnaire (or indeed of the interview, although constancy of form is much harder to maintain in the latter).

Novack *et al.* followed their scenarios with multiple choice options offering a set of possible reasons for the respondents' initial choice[22]. I decided to adopt the same format in the pilot stage of the questionnaire. When respondents filled in the questionnaire, I witnessed instances where respondents selected an option which, after reflecting on the other options, they later changed. In other words, the options acted as an educational tool. This was confirmed by respondents' own acknowledgements that the interview or questionnaire had altered their views. This is an interesting finding in itself, and suggests that presenting stakeholders with various arguments may alter their views on the acceptability of deception in medicine. It is conceivable that persons who are categorically opposed to all forms of deception whatever the circumstances may, on reflection, change their minds and adopt a more permissive attitude. Education and reflection on the ethics of deception may be one way to reconcile superficially differing views on the issue.

Unlike Novack *et al.*, I was also interested in finding out perceived moral differences between various types of deception and so incorporated answers in the questionnaire representing different deceptive strategies, such as omissions, evasions, equivocations and outright lies[22]. This allowed me to assess the respondents' preferred modes of deception.

The final section of the questionnaire mirrored Novack *et al.*'s questionnaire in asking general questions about attitudes and beliefs about the use of deception in

medicine[22]. Although these were broad questions, the preceding section will have exposed the respondent to an array of concrete situations. The respondents would thus be better prepared to answer more general questions at the end, rather than at the beginning of the questionnaire.

Piloting

The pilot study involved pre-testing the questionnaire on doctors, medical students, and members of the general public, and discussing aspects of the questionnaire itself, such as ease of use, length, and clarity of questions, with members of each of those groups. As a result of this feedback, the wording of the questionnaire was considerably simplified by avoiding medical jargon (e.g., hypertension) and uncommon vocabulary (e.g., inadvertently) as much as possible. The syntax of certain sentences was also changed to facilitate comprehension and to minimize 'leading' phraseology. Some additional options were incorporated in the questionnaire and factual inaccuracies were corrected or made more realistic. For example, the 70% mortality rate of patients waiting for a heart bypass operation was reduced to a more plausible 40%.

Following Bryman's emphasis on the importance of using believable scenarios, I took considerable care in constructing scenarios that were plausible to both doctors and non-doctors[227](p.154). Obvious factual errors or inconceivable, far-fetched situations would prevent doctors from involving themselves in the case and would reflect poorly on the researcher. Furthermore, the respondents might dismiss the scenario as implausible and answer the questions half-heartedly, grumbling at the lack of verisimilitude. Holm encountered this problem in his study[200]. In one of his case studies, Holm describes the simultaneous arrival of two patients with cardiac arrest at the casualty ward: it is night time, the senior doctor has left the hospital and the respondent is the only doctor on call. Holm was presumably interested in uncovering the doctors' views and reasoning on the ethical issues of the case, primarily those concerning which of the two patients to treat first, yet in his discussion he commented that 'many of the respondents spent quite a long time explaining why the situation would not happen in real life, so that they would not have to make this choice'[200](p.114).

The fact that this would never happen is irrelevant to the purpose of the particular scenario. The question merely asks what they *would* do, hypothetically, in these circumstances and thereby aims to isolate factors considered pertinent to priority setting, but the practically oriented doctors were obviously frustrated by the unnecessariness of the moral dilemma. The inclusion of clinicians in the construction of the scenarios ensured that the medical aspects of the cases were plausible.*

There is another reason why realistic scenarios are methodologically important. Hypothetical scenarios which are too far removed from reality can lead to misleading conclusions due to the room left to the respondents' imagination. As Wilkes notes, fantastical thought experiments 'take us too far from the actual world, and from the "other things" that hold roughly "equal" here'[247](p.45). The stranger the scenario, the more difficult it will be to keep the background conditions constant. If the latter are variable, then the conclusions of the thought experiment cannot be clearly attributed to the allegedly isolated factor. They could be the result of a number of factors modified as a consequence of the initial change. The medical and situational plausibility (i.e., the scenarios do not take place in unusual environments) of the scenarios reduced -- but did not eliminate -- the danger of conflating foreground and background factors.

Why questionnaires?

The advantages of using questionnaires to gather data on deception are many. First, the quasi-identical questions and wording of the two questionnaires (one for doctors, the other for patients and members of the public) permit a direct means of comparison between the relevant groups. As deception in medicine is a sensitive issue, questionnaires can ensure anonymity for the respondents and are thus more likely to generate responses in accord with the respondents' true beliefs[248](p.90). The absence of an observer or interviewer overviewing the process eradicates the possibility of influencing the respondent through the observer's presence (the

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* I must confess, however, that one doctor complained that case 4 was unrealistic. Yet, although such a scenario would be extremely rare, it undoubtedly could occur and if it did would create a stark confrontation between honesty and non-maleficence.

'interviewer effect')[227](p.130). Finally, questionnaires obviate the need for an observer and can be completed by a greater number of respondents.

On the other hand, the rigid format of questionnaires limits the possibility of unusual answers (i.e., answers not listed in the range of given options) and prevent in-depth explanations of choices. Reasons for answers cannot be clarified or expanded at great length, as they would in a face-to-face interview, and there is no way of telling whether the respondent followed the order of the questions. For a project aimed, in part, at understanding the underlying rationale for the moral acceptability or unacceptability of deception, these limitations are considerable.

To overcome the limitations of this method while keeping its many advantages, I adopted a multi-methods approach, also known as triangulation (see p.159). I also included opportunities for respondents to add their own comments on the questionnaire should they be dissatisfied with existing options or simply wish to expand on a point. Finally, I invited respondents to leave their contact details. Many did, and I often e-mailed those who appeared to contradict themselves or whose explanations were unclear for confirmation or clarification. I also contacted respondents for further explanations of their position on particular cases. This additional option made the questionnaire closer to a protracted interview than a traditional survey.

From a methodological perspective, one surprising finding arising from the questionnaires was the richness of the data. Due perhaps to the respondents' interest in the topic, their strongly felt views, the complexity of the issues necessitating elaborate answers, or the inviting layout of the online questionnaires (allowing respondents to type an answer of any length), the responses from the questionnaires, taken collectively, provided immensely rich qualitative material. This methodological 'discovery' casts doubt on the commonly held belief that questionnaires are of limited use in qualitative research.

The pragmatic function of the questionnaires

Some empirical studies rely on questionnaires as the sole method of data collection. As a result of this reliance on a single method, great care is taken to ensure that all aspects of the method, from the content and structure of the survey to the statistically required sample size, are as close to perfect as possible. In this study, which uses a multi-methods approach, the questionnaire served a more pragmatic function, which was to provide *broad indications* of quantitative information as well as to indicate *areas of theoretical interest* that could be elaborated in the interviews and focus groups. The relatively small sample size and the large number of open-ended questions that, in other empirical studies, might be viewed as statistical and methodological limitations are not so limiting in the context of this project.

Interviews

The qualitative interview was the most obviously suitable method to examine my research questions. Oppenheim writes that depth interviews are 'concerned with trying to understand how ordinary people think and feel about the topics of concern to the research'[249](p.67). Arksey and Knight stress that interviews are 'a powerful way of helping people make explicit things that have hitherto been implicit -- to articulate their tacit perceptions, feelings and understandings' [250](p.32). Qualitative interviews thus provide a window through which the private understandings of the respondents can be discerned, allowing the researcher to explore the reasoning processes of the respondents in ways unachievable with questionnaires.

The interviews are particularly appropriate when investigating areas about which little is known. Ideas, themes and concepts emerge from the interactions, some of which may not have been considered prior to the conduct of the interviews themselves. It is no surprise, then, that Holm adopted this method in his study on the ethical reasoning of medical professionals in Denmark[200].

As I discovered during the pilot study, some respondents have personal experiences relating to deception in medicine. Some respondents reported family members who had been deceived by their doctors. Others had been embroiled in a familial 'pact of secrecy', which involved hiding a poor prognosis from a dying relative. The conversational nature of the interview is well suited to the exposition and examination of personal narratives. Such events can be recounted in considerably more depth in interviews than in questionnaires, due in part to the nature of the spoken medium and the possibility of probing.

In face-to-face interviews, doctors may be more willing to disclose incidents involving deception which they have witnessed, participated in, or heard about than in questionnaires, where the information must be put in writing, or in focus groups, when surrounded with potentially disapproving colleagues. As Kvale wrote, the interview is an 'inter view, an interaction between two people'[251](p.35). As such, interviews are by nature more intimate and hence more conducive to the sharing of 'sensitive' information.

Informal, opportunistic interviews

Although many textbooks on qualitative methods refer to formal, carefully prepared interviews between researcher and informant, there exists another way in which to acquire information: informal discussion or interviewing[252]. Gilchrist and Williams comment that 'much information is often revealed in casual conversation and needs to be recorded in the form of field notes'[252](p.77). Grounded theorists have also used data gathered from informal interviews as part of their corpus for analysis[253].

On the bus from London to Oxford, a middle-aged woman recounted to me how her family collectively agreed to withhold a diagnosis of cancer from her dying grandmother. She described her initial shock when her mother suggested the idea and at how 'things were probably different then' [in the days of her grandmother]. It was a fascinating account and it seemed a pity not to incorporate such opportunistic but enlightening discussions in the analysis. Following such

unexpected dialogues, I noted down points of interests either at the time of the conversation or, if inappropriate, shortly after from memory.

Triangulation

Popularized by Denzin in 1970, triangulation in qualitative research refers principally to the combining of two or more methodological approaches to investigate the same phenomenon from different viewpoints[254 255].* Sarantakos writes that triangulation uses 'the strengths of each method to overcome the deficiencies of the other' and is also employed 'to overcome the deficiencies of single-method studies'[255](p.169). Triangulation allows the researcher to examine a question or event from multiple perspectives and avoids the reliance on a single data source.

There are two main reasons why researchers use triangulation. The first is to *confirm* the findings of a particular method (thereby increasing the validity of the results), and the second is to *complete* the findings by raising new issues [250](p.21-22).† In my research, it served both purposes. The reasons that interviewees gave for favouring or avoiding deception, for example, were compared with the answers from the more structured questionnaires, where pre-determined reasons were provided. If the interviewees provide similar reasons to the ones offered in the questionnaire, then this tends to confirm that those reasons are indeed pertinent to the assessment of a deception's acceptability. If, however, some interviewees provide reasons that were omitted in the questionnaire, this would add to the completeness of the options.

To again illustrate how triangulation can confirm findings, the questionnaire results from case 1 showed that some two thirds of my 'patient' respondents were against informing Susan and her father of their biological non-relatedness. In a focus group, attended by 18 cardiac patients, a show of hands revealed that 11 out

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* Denzin also discussed 1) data triangulation, where different sources of data are used to arrive at a richer description of an event or phenomenon; 2) investigator triangulation, where various researchers are used to confirm interpretations and limit bias; and 3) theory triangulation, where several theories are applied to examine the data.

† Gibbs defines validity in research as 'the concern that the theories or explanations derived from the research data really are true, that they correctly capture what is actually happening'[256](p.13).

of 17 (65%) were against disclosure. The similarity between the results of two (or more) methods can increase our confidence in their validity.

Following the trend of triangulating various methods, I decided to combine the informative but relatively rigid questionnaire method with two methods allowing for detailed elucidations of concepts and attitudes: focus groups and semi-structured interviews. Focus groups, for all the reasons previously mentioned, both complemented and enriched the other chosen methods of data collection.

Arksey and Knight have emphasized the usefulness of combining interviews with questionnaires, saying that the latter are 'a good check on an interpretation of interview data', 'a way of exploring how widely views, feelings and understandings are shared' and a 'quick-and-dirty way of getting a sense of issues to be explored in interviews'[250](p.33).

Triangulation, however, is not devoid of problems. The choice of combination must be justified methodologically, as not all methods are theoretically compatible. Some critics claim that studies that use triangulation are difficult to replicate and that such studies are not necessarily better than those using single-method procedures[257](p.146). A philosophical critique questions the possibility of knowing that several methods are converging on the 'correct' phenomenon. They may all be wrong[244]. Finally, on a purely practical level, the combination of various methods is both time-consuming and costly.

Purposive sampling

Ritchie, Lewis and Elam define a sampling strategy as purposive (or strategic) when the 'sample units are chosen because they have particular features or characteristics which will enable detailed exploration and understanding of the central themes and puzzles which the researcher wishes to study'[258](p.78). The chosen samples were therefore selected on the basis of their likely involvement with deception in medicine. Within the category 'doctors', the groups initially deemed most theoretically interesting for the study were oncologists, dermatologists and general practitioners.

Oncologists

Most empirical studies on truth-telling have focused on the disclosure of cancer diagnosis or prognosis.* Although great advances have been made in the last 40 years in the treatment of many forms of cancer, it is still the number one cause of death among men living in the United Kingdom[259]. In the United States, Gordon and Daugherty quoted a figure of 500 000 deaths each year from advanced cancer[143](p.144). To disclose a prognosis of advanced cancer, when conventional treatments such as chemotherapy or radiation therapy are no longer effective, is, in the words of Gordon and Daugherty, to 'acknowledge that the chances for cure no longer exist'[143](p.144). The prevalence of cancer, coupled with the extreme gravity of the disease in some forms, make oncology a field where the decision to disclose or withhold information to patients is likely to be relatively frequent. As a result of this involvement, oncologists may have theoretically interesting views on truth-telling and deception in medicine based on their own clinical experience.

Dermatologists

Dermatologists, on the other hand, are less likely to encounter situations where deceiving the patient may be a realistic option. Dermatologists seldom face situations where the disclosure of medical information could have such a significant impact on the patient that nondisclosure, evasion or lying may be ethically desirable. Furthermore, dermatological problems are usually visible to the patient, and cannot be concealed to the same extent as invisible, internal conditions. Aggravations are patently evident to the patient and can hardly be denied by the doctor. Moreover, most patients with skin cancer (other than malignant melanoma) are seen by dermatologists at an early stage of the disease, when it is still curable. This is unlike some other forms of cancer, such as ovarian cancer, which are typically seen at a much later stage of the disease and where the chances of completely removing the cancer are relatively small.

There are also few lethal dermatological conditions. Of course, there are exceptions, such as melanomas, but practically all doctors will be faced at some point with situations where deception could conceivably be used to benefit

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* For example, see [196 259 143].

patients. As far as medical specialists go, however, dermatologists have relatively little motivation for deception and as such would provide a suitable counterpoint to oncologists. Fitts and Ravdin, in a study examining the tendency of doctors to disclose a cancer diagnosis, found that of the eight selected specialty groups dermatologists were the most likely to inform the patient of a cancer diagnosis [178]. Whereas approximately 70% of doctors never or usually did not tell their patients about the diagnosis, 94% of dermatologists did disclose this information. The authors explain these results by arguing that 'dermatologists treat cancer with an unusually favorable prognosis and their patients can be cured in the majority of instances'[178](p.902). Even in 1953, then, dermatologists were inclined to be honest about cancer.

General Practitioners (GPs)

As 'all rounders', GPs would be involved in some way in all of the scenarios included in the questionnaire. They deal with patients with a broad range of medical conditions. Furthermore, GPs usually know their patients better than specialist doctors due to the regular and continuous nature of the GP-patient relationship. GPs will have known many of their patients for several years and have a better idea of the personality, values, and beliefs of their patients than specialists who might only see their patients once or twice. The relationship between GPs and their patients is generally of a different nature from that between dermatologists or oncologists and their patients. This closer rapport between GPs and patients may affect GPs' ethical outlook on the acceptability of deception in medicine.

Although these three groups were deemed of particular theoretical interest, I did not exclude doctors who did not fit into the categories above. The group 'doctors' included all practising doctors in the UK, thus all people fitting this criterion were allowed to participate in the project. Focusing only on the three sub-groups may have provided an unrepresentative picture of the views and reasoning of doctors in the UK. From a practical standpoint too, it would have been tremendously difficult to recruit a sufficient number of dermatologists or oncologists in the study.

Initially, I aimed to recruit patients from each of the three main groups above (i.e., cancer, dermatology and GP patients). However, it emerged that doctors were reluctant to invite some of their own patients to participate in the study. I therefore elected to recruit all types of patients, irrespective of the specific medical condition or its gravity, as long as it was likely that they had, at some point, more than average contact with the medical profession. It is a vague definition, partly reflecting the fuzzy boundary between patient and non-patient, but I avoided borderline cases by approaching patients with recognised, usually chronic diseases. By their own accounts, 87% of patients who completed the questionnaire considered the severity of their illness as 'moderate', 'severe' or 'very severe'. Conditions included pancreatitis, HIV/AIDS, haemophilia, hepatitis, endocrine disorders, and diabetes.

Exclusion criteria

For ethical reasons, I excluded from the study people deemed too ill, too emotionally labile or fragile, incompetent, or in other ways unsuitable for participation. As I wished to focus on competent, adult members of the community, persons under 18 were excluded from the study. Non-English speakers were also excluded, purely to avoid overwhelming practical difficulties (e.g., translating all documents and transcriptions). Some of the implications of these exclusion criteria on the study are mentioned later in the chapter.

Ethical approval

The main ethical consideration concerned the sensitive nature of some scenarios contained in the questionnaires, interviews and focus groups which might have upset certain respondents. To reduce the chances of emotional distress, participants were provided with an information sheet detailing the nature of the research and what participation would entail. Interviewees were verbally briefed about the content of the interview, asked to sign a consent form (unless the interview was opportunistic, in which case only verbal consent was obtained) and given the opportunity to withdraw from the study at any point. Still, one questionnaire respondent refused to answer questions relating to one scenario (in

which a patient is given a wrong and lethal dose of medication) because it was "too horrible". All collected data were securely kept on my desktop computer or in a locked filing cabinet in my house. The study was approved by the Oxfordshire Research Ethics Committee in May 2004.

Sample size

Unlike quantitative studies, which require sufficient numbers to achieve high statistical power, there is no hard and fast rule about the size of qualitative studies.* Generally, qualitative research does not require large sample sizes. Qualitative researchers are not concerned with the incidence or prevalence of events or phenomena, but with the range and nature of phenomena themselves. Sufficient data must therefore be collected to reveal the full diversity of relevant phenomena, given the population and the purposive dimensions.

Qualitative researchers study the phenomena in-depth, rather than *en masse*. Although it is time-consuming, a detailed qualitative investigation generates huge amounts of data. Ideally, data collection will cease when no new phenomena are discovered. This is referred to as 'data saturation'. Holm, for instance, interviewed 33 doctors and 9 nurses before saturation was reached[200](p.94). In the present study, excluding the pilot, 229 questionnaires were processed (85 doctors, 88 patients, 56 members of the public), 35 semi-structured interviews (15 doctors, 9 members of the public, 11 patients), 5 opportunistic interviews (4 doctors, 1 patient) and 2 focus groups were conducted. After 30 interviews or so, hardly any new data emerged during coding and, after 35 interviews and still no further insights, I decided that saturation was reached.

Recruitment

Participants were recruited from Oxford and London. Some doctors were identified by approaching contacts in the oncology and dermatology units of the John Radcliffe hospital in Oxford. Through these contacts, the names of other

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* The 'power' of a test refers to the probability of rejecting a null hypothesis when the null hypothesis is false.

specialists were obtained through 'snowballing' (or 'chain-referral') techniques. Snowball sampling involves establishing contact with a few respondents and then using them to recruit others. Since my research was qualitative, the main objection to snowball sampling -- that the findings cannot be generalised because of the unrepresentative sample -- is less of a concern than if I were conducting quantitative research[227](p.98). GPs were selected from surgeries in the Oxford area, and invited by e-mail to participate in the research.

Many doctors were recruited opportunistically in conferences, through contacts, via doctors' mailing lists, or socially. Patients were recruited through patient websites, newsletters and mailing lists. Eighty eight patients were recruited in total, although a particularly successful advertisement on the British Thyroid Foundation website meant that 38 of those came from a particular patient group suffering from thyroid problems. The thyroid patients' questionnaires were analysed separately to assess whether there were significant differences between patient groups. As none were found, all the patients' results were combined. Although it still remains statistically insignificant, the similarity between the 'thyroid' group and 'general' patient group increases confidence in the quantitative accuracy of the questionnaire.

Members of the public were selected by convenience and purposive sampling and recruited in public places, mostly on train journeys between Oxford and London.* All respondents were encouraged to invite friends and acquaintances to complete questionnaires or to be interviewed ('snowball sampling'). Once again, since the research is concerned with examining the range of views and rationales, respondent-driven sampling need not be methodologically problematic.

Although the interviews and focus groups were conducted face-to-face, the questionnaires were given by hand or completed electronically on the World Wide Web. Posting the questionnaires on the web ensured respondent anonymity, was generally easier to complete, considerably cheaper, and no doubt generated results faster than their postal counterparts. A number of health-related research projects

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* A convenience sample is one chosen because it is readily accessible to the researcher[227](p.97).

using electronic surveys have been conducted[260]. The extant studies which compare the validity of web-based questionnaires with the same questionnaires conducted in the 'traditional' manner suggest that 'the validity and reliability of data obtained online are comparable to those obtained by classical methods'[260].

Initially, I was concerned about inviting participants to complete questionnaires on-line, in particular about ethical issues relating to consent and confidentiality. The front page of the website thus provided basic information about the research project and strongly encouraged prospective respondents to read the information sheet (also posted on the website) before accessing the questionnaire. I also invited visitors to contact me if they had any questions relating to the project. To protect confidentiality, 'submitted' on-line questionnaires did not reveal the identity of respondents. The questionnaires were also placed in a password-protected area of the website to avoid respondents who did not fit the inclusion criteria.

Grounded Theory

Grounded Theory (GT) was developed by Barney Glaser and Anselm Strauss in the 1960s[261]. It refers to the development of a theory based -- or 'grounded' -- on the systematic analysis of data. As Strauss and Corbin explain, in GT:

> A researcher does not begin a project with a preconceived theory in mind. [...] Rather, the researcher begins with an area of study and allows the theory to emerge from the data. [...] Grounded theories, because they are drawn from the data, are likely to offer insight, enhance understanding and provide a meaningful guide to action[19](p.12).

Although some commentators have criticised the prescriptivism and the positivist assumptions of GT, the methodology has been used to good effect in qualitative research in health care, such as in Charmaz's study on men's experience of chronic illness or Orona's analysis of identity loss and Alzheimer's disease[262 263].*

Holm, who also chose GT to examine the moral reasoning of doctors and nurses, states that GT methodology is 'very suited for studying ethical reasoning' on the

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* For an overview of the epistemological critiques of GT, see Charmaz, K.[264]

basis of its structured approach and its close reliance on the statements of the research subjects[200](p.82). GT lends itself to the examination of ethical reasoning because it uses a kind of 'reflective equilibrium', which revolves around the interplay between data and theory. The advantage of this is obvious. If this project aims in part to offer healthcare professionals a more detailed set of suggestions than currently exists, these suggestions must be achievable. The average doctor must be able to follow any normative proposals that may emerge from the study.

Another advantage of GT is that it does not require the application of a preconceived theory, but allows one to emerge, inductively, from a careful analysis of the data itself. The theory thus naturally fits around the data, rather than the data being interpreted in the light of an imposed theory. Of course, researcher bias is unavoidable and I have undoubtedly brought into the analysis and interpretation my own views, assumptions and knowledge. Nonetheless, I did not embark on the project with a preconceived consequentialist, deontological, or virtue theoretic perspective. I did not hold a staunch view on the matter of benignly intended deception in medicine. This project was, in part, a personal search for satisfactory solutions to the problems surrounding deception in medicine and an exploration of my own ethical views on these issues.

The very process of generating the theory by coding data into categories, relating categories to subcategories, and, finally, integrating the concepts into an explanatory theory is highly informative. The steps above use the method of 'constant comparison', which systematically compares codes and categories across data sets and ultimately develops and refines the overall theory[244](p.96). A microscopic (or 'line-by-line') analysis of data was performed in the initial stages of the research until no more codes were found. Once the codes were listed, a more selective approach was adopted. Strauss and Corbin do not denigrate this less exhaustive method: 'Usually, microscopic coding of 10 good interviews or observations can provide the skeleton of a theoretical structure'[19](p.281). Of course, the skeleton requires fleshing out but this can be achieved by selecting passages of interest.

Grounded Theory in practice

The basic components of Grounded Theory are concepts and categories. These components are discerned through the coding process and constitute the building blocks that contribute to the construction of the overall theory. Strauss and Corbin define a concept as a 'labeled phenomenon [...] an abstract representation of an event, object, or action/interaction that a researcher identifies as being significant in the data'[19](p.103).

Like an anatomist, the researcher 'opens up' the text and looks for phenomena of interest to the study before naming them and finding relationships between the various labels. This is called *open coding*. It represents the first stage in analysis. Through line-by-line analysis of the text, I identified recurrent views and opinions that I considered relevant and labelled them with conceptual labels ('codes'). The preliminary analysis resulted in 140 different codes. From then on, other statements that referred to the same idea were given the same label (e.g., 'special status of direct questions' or 'role of patient's personality on information giving').

To avoid facing vast amounts of raw data, I started open coding as early as the first interview, gathering preliminary concepts and categories. The immediate start of the analysis allowed me to refine and elaborate the categories as the project progressed. Once no more codes emerged, I attempted to make sense of the apparent chaos by building a model using the NVivo software.* The diagram was a web of interconnected codes, with broad codes encompassing more specific but thematically related codes. This allowed me to visualise the data and develop initial ideas on the relationship between the codes. Redundant codes were also eradicated and free-standing codes temporarily put aside. Strauss and Corbin label the process of relating categories to each other and to subcategories 'axial coding'[19](p.124).

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* Gibbs notes that the design of NVivo was heavily influenced by Grounded Theory and is hence ideally suited for a GT analysis[256](p.165).

One step up in the theoretical hierarchy, categories are more abstract than concepts and, under a single heading, encompass several concepts, as shown in the diagram below:

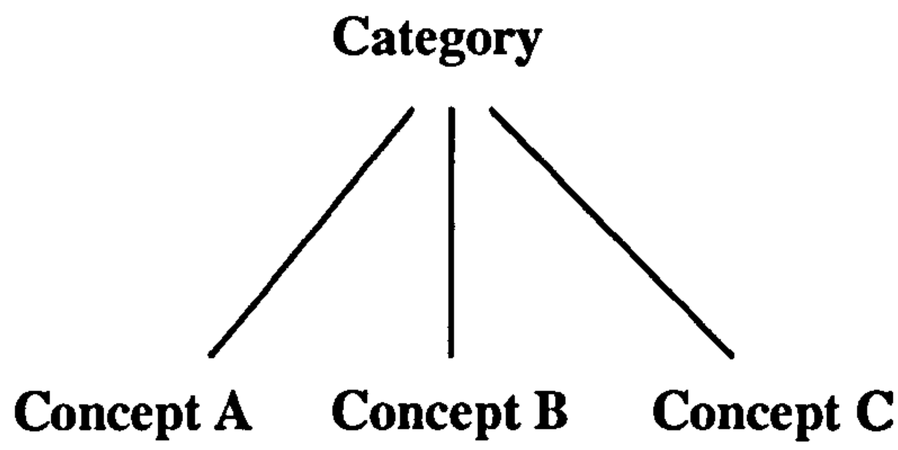


Figure 4: diagram showing the relationship between concepts and categories

A category thus consists of conceptually related components. Since working with 140 codes was unwieldy and time-consuming, I reduced the number of analytic units by grouping together several concepts into categories. As an illustration of this process of refinement, I started with the following codes gathered from a line-by-line analysis of questionnaires and interviews:

- Patient's enquiring attitude
- Use of questions as indicators of preference
- Internally questioning the doctor
- Pretending not to know to gain second opinion
- Request for clarification
- Use of secondary sources (Internet, books, support groups)

After some reflection, I realised that these were all overlapping *strategies* that helped patients obtain, either overtly or covertly, information from the doctor or details about their condition. From this observation, I derived a category 'patient as explorer' (see p.230).

Eventually, four 'root' categories were identified and used to sort the data in a more focused manner. These were:

1. Defining deception
2. Acceptability of deception
3. Functions of deception
4. Mutual sharing of information

Once categories have been generated and developed through coding, they can be integrated into a theoretical framework. This is done through *selective coding*. The first step in integrating the categories is finding a central (or 'core') category related to all the other categories. All the discrete themes gathered in the analytic process thus far must be subsumed under one 'core' theme. Holm, for example, after noticing that the notion of responsibility was pervasive in his data, chose 'protective responsibility' (i.e., a responsibility to protect patients) as his core category. This label, for Holm, was 'able to provide an adequate explanation of the ethical reasoning of the health care professionals studied here'[200](p.125).

Selective coding also refers to refining the theory by ensuring internal consistency (i.e., by accounting for negative instances ('deviant' cases) which appear to contradict emerging themes and ensuring that everything 'fits' without inconsistencies), filling in underdeveloped categories, getting rid of superfluous categories, and validating the theoretical framework by checking how useful the theory is when applied to raw data.

Unlike Holm, I did not structure my analysis around a single, core category, preferring instead to divide the analysis into the four more manageable and theoretically compact categories listed above. A core category, labelled 'uncertainty', was considered but later deemed too generic and theoretically diffuse to provide any meaningful insight. My methodological approach is thus not *pure* Grounded Theory but is rather *informed* by Grounded Theory approaches.* It uses analytic tools characteristic of GT, although it does not claim to derive any grand or novel theory from the data.

Another way in which the study differs from pure GT is that the literature review was performed *before* data collection and analysis, not after. Although this might have 'polluted' me by instilling views inconsistent with the theoretical 'blank slate' desired by some grounded theorists, it was essential to identify gaps in knowledge and to derive empirically testable questions to address those gaps[266].

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* It is not entirely clear what now counts as *pure* Grounded Theory as even the two original proponents of the theory, Strauss and Glaser, have diverged in their views on how to use GT. Kath Melia even talks of a 'midlife crisis of identity' for Grounded Theory[265](p.378).

Finally, contrary to pure GT, memo-writing was performed in one continuously revised text, not dozens of discrete 'chunks'[267]. I found this method more fluent and thematically clear than the staccato approach of memo-writing propounded by Strauss and Corbin[19](p.218).

While the analysis, from the open coding to the finishing touches, is systematic in theory, there is a certain amount of creativity involved in constructing a Grounded Theory. Finding illuminating explanations for phenomena and the relationships between various categories requires inventiveness. There is no single, 'correct' way to conduct a Grounded Theory analysis, as there might be for some quantitative methods. As Strauss and Corbin write:

> Analysts who rigidify the analytic process are like artists who try too hard. Although their creations might be technically correct, they fail to capture the essence of the objects represented, leaving viewers feeling slightly cheated[19](p.129).

Methodological limitations

Derek Layder has criticised the Grounded Theory of Strauss and Corbin for its excessive focus on observable or recordable data:

> The GT approach tends to encourage the researcher to focus on the 'close-up' features of social interaction and, in this sense, neglects the seemingly more remote aspects of the setting and context[268](p.55).

By examining the data with a magnifying glass and deriving the theory from the observed data, Layder accuses GT of ignoring the macro issues, such as the social, historical and institutional factors affecting the phenomenon in question. This seems to be a valid criticism of GT. Nonetheless, I believe this objection does not undermine the usefulness of this thesis, as the empirical component has a fairly restricted focus, concentrating on people's views and reasoning on the issue of truth-telling and deception in medicine. It is not directly concerned with broader issues, such as the social structure of the hospital or the hierarchical relationship between doctors and patients, or between junior and senior doctors. An in-depth examination of these issues is beyond the scope of this thesis.

In various places, however, I do mention some of the issues above and other social and institutional factors which may explain some data or enrich a particular interpretation. This is another way in which my methodology differs from 'pure' GT, since the interpretation is primarily, but not entirely, guided by the empirical data. My aim was not to develop a pure GT, but to use the analytic tools of GT to describe and explain the views and reasoning of respondents on the issue of truth-telling and deception in medicine. Once this was achieved, I applied argument-based, philosophical analysis to evaluate the findings.

The empirical chapters (chapter 7-10) serve a dual function. First, they represent what I hope is an accurate account of stakeholders' own accounts of a range of issues which I wished to investigate, from the definition of deception to its moral dimensions. Second, as the project involves an interplay between social science and medical ethics, I attempted to go beyond the presentation of an account in order to evaluate and to some extent formulate bioethical arguments. The status of the empirical data is quite distinct in each case. In the first, I present a 'story' derived from data gathered from interviews, questionnaires and focus groups. In the second, the data are used as a springboard for my own personal philosophical enquiry.

Charmaz has emphasized the potential weaknesses in using the GT method. These include a premature commitment to a set of categories, using unnecessary jargon, and uncertainty over the meaning of terms such as 'saturation' and 'category'[267]. As mentioned earlier, I performed a line-by-line analysis of the first few interviews and questionnaires until no more codes were found. The codes were then grouped thematically and developed into categories. As the coding process was not rushed, I do not believe Charmaz's concern about premature commitment to categories is substantiated in the present study. Regarding the two other points, I have striven to avoid esoteric jargon, preferring instead category labels that are informative rather than opaque, and have consistently used the terminology employed by Strauss and Corbin in their popular text *Basics of Qualitative Research*[19].

This study was conducted in a relatively small geographical area and with several dozen participants. As a result, one should be wary of generalising the findings to the whole population. Although I have taken great care in recruiting a wide variety of doctors, patients and members of the public, I cannot of course be sure that other people in other parts of the country have the same set of views and underlying reasons on truth-telling and deception in medicine. Further research would be needed to discover if this is the case. Furthermore, I did not include very severely ill and bed-ridden patients in the study to avoid the risk of distressing them. By virtue of their condition, such people may have very strong views on the acceptability of benignly intended deception. Since I did not include this population, I cannot be confident that my level of data saturation delineates the theoretical limits of people's views and reasoning on the issues addressed. As Seale notes, this is the general problem of induction: the researcher cannot know for certain that further data collection will not reveal a new idea or a deviant case which may require the theory to be modified, even if it appears that saturation is reached[244](p.93).

The recruitment methods may have led to a biased selection of patients. Some patients were invited via patient websites and message boards. The patients who responded were self-selected and might have had life events that drew them to the subject matter. This may explain why so many patients wrote that they had, at one time, been deceived by their doctor. This leads on to another possible bias. Patients will have recalled their past experiences subjectively and possibly inaccurately; they may have highlighted certain features and downplayed others. As the interviews were only semi-structured, the form of the interview itself varied from participant to participant, depending on the answers given. This discrepancy, coupled with my relative inexperience in qualitative interviewing, might have affected the validity of direct comparisons between individual interviewees. The context of the interview and the relationship between interviewer and interviewee can influence what is said, and this is especially true in a project that includes a moral dimension.

Every research method has its limits. With semi-structured interviews, there is the aforementioned danger of researcher bias. Although I took great care in framing

the questions in a non-leading manner, I have no doubt that my personal worldviews have on occasion surreptitiously crept into the formulation of questions (and, indeed, into the analysis of data). A second weakness relates to the reliability of respondents' answers. How accurate or honest are the views expressed by the interviewees? The multi-methods approach, although unable to eliminate the problem of reliability, can at least reduce it through comparisons of data between methods. A third weakness is that the interviewees -- especially doctors -- might well have given answers that they considered socially desirable. I tried to limit this by emphasizing that their contributions would remain anonymous and that there were no necessarily right or wrong answers to the questions.

The uncertainty and hesitations found in the answers of many respondents suggest that even in-depth interviews imperfectly capture people's moral thinking or that respondents' views and reasoning are not well formed on certain issues. In the psychology literature, proponents of the 'philosophy of basic values' have argued that people are unable to articulate well formed preferences on unfamiliar issues and thus may 'construct' preferences (i.e., express more or less unreflected preferences), while opponents of this view -- who adhere to the 'philosophy of articulated values' -- argue that individuals can express well formed preferences on virtually anything[269](p.295). The present research supports the thesis that people may not clearly articulate their views and reasoning on unfamiliar topics, although it does not necessarily follow that these people entirely 'constructed' their remarks. Nonetheless, such a possibility should be borne in mind.

Related to the discussion above, the beliefs and reasoning of interviewees seemed to shift in the course of the interview. Indeed, some respondents arrived at conclusions they had not initially anticipated. For example, various patients and members of the public said at the end of the interview that, from then on, they would ask their doctor more direct questions. A little under half of all the 229 survey respondents claimed that the exercise had affected their views of deception in medicine. I do not see this malleability as a methodological flaw but rather as a reflection of the uncertain or, in some cases, 'raw' nature of people's moral reasoning on this issue. Indeed, the ability of interviews to capture the uncertainty

first-hand may be seen as an advantage over methods which produce artificially tidy accounts. The messiness of people's moral reasoning on deception is, in my view, an important finding.

The purpose of the hypothetical scenarios was to isolate certain factors that could influence people's perception of the morality of deception. Although each scenario in the questionnaire was tested on respondents at the pilot stage, a few respondents appeared to differ in their interpretation of the hypothetical situations. This is a recognised weakness of the vignette technique[227](p.154). For example, some respondents believed that failing to treat Mr Smith immediately would result in his death, despite the description within the scenario that Mr Smith's cancer was 'quite successfully treatable with modern drugs and chemotherapy'. It is possible, then, that some answers were influenced by respondents misreading the scenarios or altering some of the background conditions. However, judging from their comments, most respondents appear to have understood the scenarios in the same way.

Despite the limitations associated with each of the various study methods, the combination of the three chosen methods -- focus groups, semi-structured interviews, and questionnaires -- aimed to reduce the deficiencies of each while keeping their advantages. The next chapters present the empirical findings and examine their relevance to the ethics of truth-telling and deception in medicine.

CHAPTER 7

Empirical Findings on the Definition of Deception

The ways in which respondents defined deception were numerous and confusing. To establish some order amidst the conceptual chaos, I collated the relevant nodes in the NVivo Model Explorer. This qualitative modelling formed part of the analytic process and shed considerable light on the interactions between the various nodes. A simplified version of the model is reproduced below:

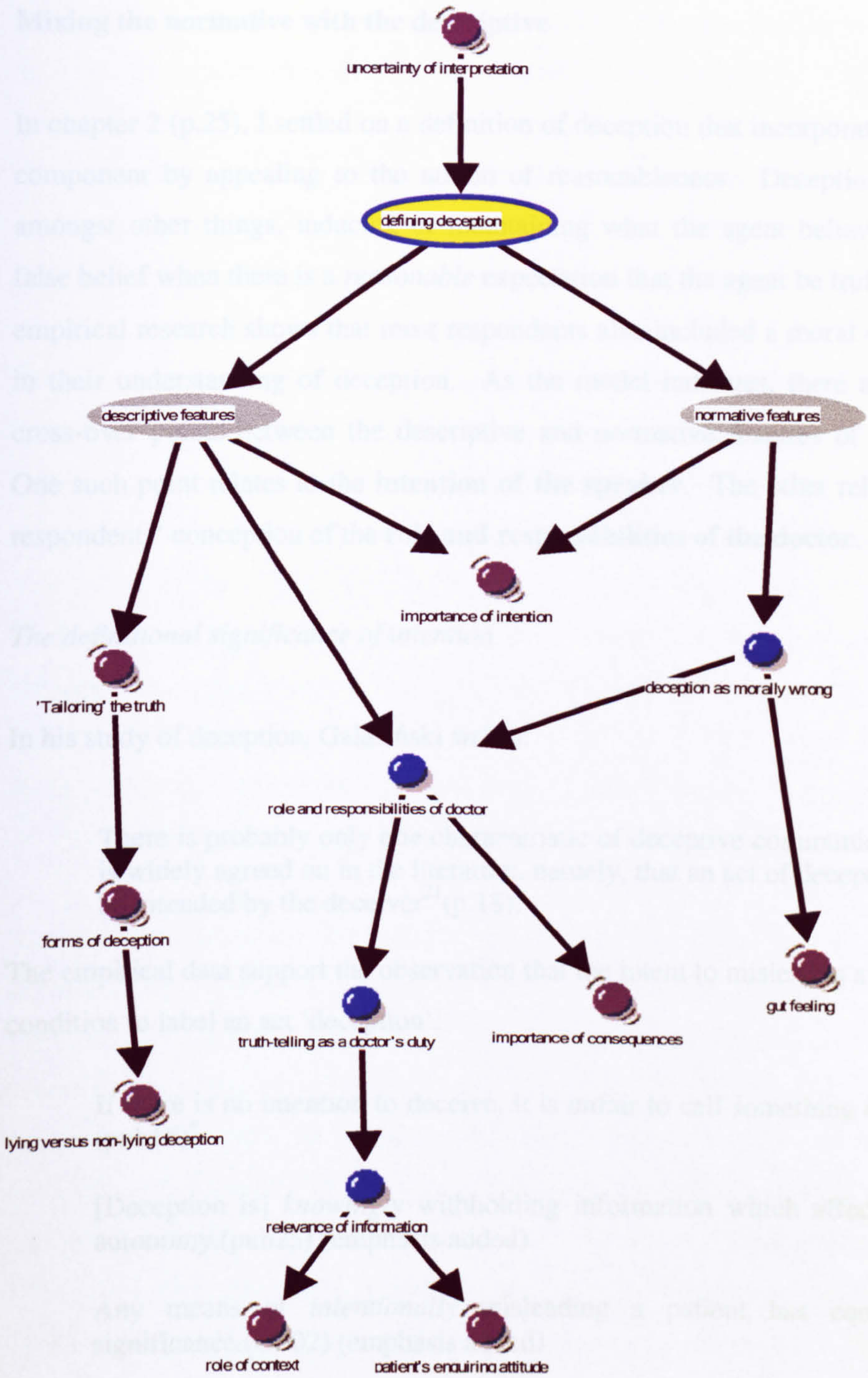


Figure 5: qualitative model showing relationship between nodes relevant to defining deception

Figure 5 displays the main categories at work in respondents' understanding of the concept of deception.

Mixing the normative with the descriptive

In chapter 2 (p.25), I settled on a definition of deception that incorporated a moral component by appealing to the notion of reasonableness. Deception requires, amongst other things, inducing or maintaining what the agent believes to be a false belief when there is a *reasonable* expectation that the agent be truthful. The empirical research shows that most respondents also included a moral component in their understanding of deception. As the model indicates, there are various cross-over points between the descriptive and normative features of deception. One such point relates to the **intention of the speaker.** The other relates to the respondents' conception of the **role and responsibilities of the doctor.**

The definitional significance of intention

In his study of deception, Galasiński writes:

> There is probably only one characteristic of deceptive communication that is widely agreed on in the literature, namely, that an act of deception has to be intended by the deceiver[21](p.18).

The empirical data support the observation that the intent to mislead is a necessary condition to label an act 'deception':

> If there is no intention to deceive, it is unfair to call something deception. (pub16)*
>
> [Deception is] *knowingly* withholding information which affects patient autonomy.(pub25) (emphasis added)
>
> Any means of *intentionally* misleading a patient has equal moral significance.(GP02) (emphasis added)

Although necessary, intention was not invariably considered sufficient to render an act 'deception'. Some respondents included a temporal condition to their definition, resulting in the non-ascription of 'temporary' deception as true

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* 'pub' refers to 'member of the public, 'pat' to 'patient', 'thy' to a patient with a thyroid disorder, 'GP' to 'general practitioner', 'onc' to 'oncologist', 'gastro' to 'gastroenterologist', 'derm' to 'dermatologist', 'neuro' to 'neurologist', 'doc' to 'doctor in other specialities', 'neurosurgeon' and 'haematologist' are self-explanatory. The numbers identify the individual respondents. The extracts are taken from questionnaires, unless otherwise indicated (e.g., onc01, interview).

deception. Pub47, for example, wrote in answer to the question 'Do you believe it is ever acceptable for doctors to deceive their patients?': 'no, however "temporary deception" i.e., an intention to tell the full truth in the future, is OK'. Similarly, when doc12 was asked if withholding information from Mr Smith (case 6) was deception, he answered: 'no, because it is only temporary'. GP12 agreed: 'no, you plan to tell in good time'.

These comments raise the following question: how much time must elapse between a speaker's intention to 'tell the truth' and the actual disclosure before the delay counts as deception? Take, for example, the following true story. In my early teens, one of my dreams came true. I received -- after much pestering -- a dog called Billy. I played with him in the garden, took him on long walks, washed him, fed him and petted him to his heart's content. Although well behaved as a puppy, his sheer vigour as a grown dog made him unmanageable and, while I was away at boarding school, my parents gave Billy away. For several months, they did not tell me Billy was gone. I only found out when, stepping out of the car at home, I excitedly called Billy's name. Not a bark.

There is little doubt that my parents intended to tell me the truth about Billy's departure, but I would still argue that their deliberate and prolonged wait made their silence a form of deception. The reason can be explained by referring to my suggested definition of deception, which includes the clause 'when the target's expectation of truthfulness is reasonable'. My parents no doubt knew that I would have wanted to be told of Billy's departure much sooner but, anticipating my sorrow at the news, they decided to delay the disclosure until my return home. In light of my deep affection and fondness for Billy, my expectation to be informed of his permanent departure within a few hours or possibly days (rather than months) was reasonable. Whatever the motivation or the moral acceptability of the act, their delay counts as 'deception'. An intention to eventually tell the truth is not *sufficient* to absolve an act of its status as deception. The intention must be acted upon within a delay contingent on the target's reasonable expectations.

Some respondents also associated deception with *malicious* intent:

> Deception has a sort of malign context, doesn't it?, that you imply that you're trying to do something unpleasant to a patient and obviously that's not what I'm about at all and hopefully what no doctor is about. (onc01, interview)

> No, it is not deception [withholding information from Susan and her father] as this implies some sort of malicious intent. (doc12)

> (No) Even if the doctor decides not to tell her, the intention would not be devious, and therefore doesn't merit the term 'deception'. (pub6)

The extra condition of maliciousness highlights the strong association, in the minds of some respondents, between deception and moral wrongdoing.

The conflation between deception and moral wrongness

Judging from their answers, respondents from all groups seem to have interpreted the question 'Do you think NOT providing the information is a form of deception' (in case 1) as something like 'do you think disclosing the information is morally wrong?'. This lends further support to the hypothesis that deception is intimately linked with morality and, in particular, wrongdoing. The conflation between moral wrongness and deception is well illustrated by this response by pub29:

> The test was not done to discover whether they [Susan and her father] were related, so not providing them with an answer is not *wrong or deceptive*. (emphasis added)

Here, 'wrong' and 'deceptive' appear to be used synonymously. Just as Miyaji showed that words such as 'malignancy' and 'cancer' were considered 'dirty' words amongst doctors, so is 'deception' amongst many of my respondents, doctors, patients and members of the public alike[15].

Below are two further extracts which exemplify the normative/descriptive conflation. In the first extract, pub56 explains why withholding a diagnosis of cancer from Mr Smith in case 6 is not deception.

> Because the current priority is to minimise the risk of another heart attack. Such a piece of news would undoubtedly increase Mr Smith's anxiety. To

> my mind, it is not in the patient's best interests, at that point, to share that piece of information.

In the second extract, a palliative care doctor provides reasons why withholding the non-paternity from Susan and her father in case 1 is not deception:

> Information, like treatment, can be withheld when the risks clearly outweigh the benefits. (doc25)

So, here, defining the act as 'deception' appears to depend on the balance of risks and benefits. The idea seems to be that if disclosure will cause great harm, then non-disclosure is desirable and does not constitute deception. For some respondents, moral desirability and deception seem incompatible or, at best, a distinctly odd pair.

Gut feeling and the apparent deception paradox

For most respondents, there appears to be a deep-rooted, intuitive 'knowledge' that deception is wrong, represented by the 'gut feeling' node in the model (figure 5). Although nearly all doctors affirmed that deception is used 'often' or 'occasionally' by doctors in the medical context, the vast majority claimed that they personally used it 'rarely' or 'never'. This is not necessarily inconsistent, as the respondents may have been a particularly honest group or simply mistaken about the prevalence of deception, but a more plausible reason is that admitting to deception is widely regarded as admitting to wrongdoing.

A dermatologist (derm5) captured the innate distaste for deception by commenting: 'the words "lying" and "deception" are so negative that the answers you get will be affected'. Yet, despite the prevalence of the view that deception is intrinsically bad, the statistics indicate that the majority of respondents from all groups believe a) that it is sometimes morally acceptable for doctors to deceive their patients and, with even greater consensus, b) that deception in everyday life may be acceptable. The results are shown in the tables below:

Do you believe that it is ever acceptable for doctors to deceive their patients?

	YES	NO
Doctors (n= 84)	70%	30%
Patients (n=86)	60%	40%
Members of the public (n=54)	81%	19%

Table 3: survey results for question 'Do you believe that it is ever acceptable for doctors to deceive their patients?'

Do you believe that it is ever acceptable to deceive someone in that person's best interests?

	YES	NO
Doctors (n=82)	82%	17%
Patients (n=87)	68%	32%
Members of the public (n= 54)	89%	11%

Table 4: survey results for question 'Do you believe that it is ever acceptable to deceive someone in that person's best interests?'

The apparent paradox is clear: people believe deception is morally wrong but also believe it can be morally right. One possible explanation is that although respondents often associate deception with moral wrongdoing, the moral component of deception is not intrinsically linked to the definition but contingent on other, extrinsic factors. The association between deception and moral wrongness could thus be seen as probabilistic, rather than necessary. Alternatively, deception might always possess a negative moral value but one which can nonetheless be overridden by other morally relevant considerations. Once specified, the paradox vanishes: most people believe deception is generally or *prima facie* wrong but accept that it may, in some cases, be morally right. The gut feeling that deception is always wrong can be overcome by countervailing right-making considerations.

The results of case 5 can shed further light on the relationship between 'deception' and moral desirability.* In case 5, where the relevance of the information is fairly clear, roughly 80% of patients and members of the public who completed the questionnaire considered an omission to disclose a 40% chance of death on a

* **Case 5**: The doctor puts the patient on the waiting list for a heart transplant. The expected waiting time is 9 months. The doctor knows that 40% of patients die while on the waiting list.

waiting list to be deception. Interestingly, fewer doctors shared this view. This difference can be explained by examining the answers to the previous question, which asked whether the doctor *should* divulge this high probability of death on the waiting list to the patient. Whilst 80% of patients and members of the public answered 'yes', only 59% of doctors did so (in this instance, the doctor respondents tended to place more emphasis on maintaining hope than other groups). The results regarding omission of information in this scenario are not surprising if my assumption that people are much more likely to call an act 'deception' if they disapprove of it is correct. Further analysis of the doctors' answers is consistent with this assumption. Of the 35 doctors who believed the doctor should *not* reveal the high risk of death, 20 (57%) did not consider the omission a form of deception. Of the 46 who believed the risk *should* be communicated to the patient, 40 (87%) believed the omission was deception. This may constitute further evidence that the descriptive and normative are often mixed in the evaluation of deception and that people's classification of what counts as deception is flexible.

Perceptions of the role and responsibilities of doctors

Many people's understanding of deception depended on their views about the role and responsibilities of doctors. One notable variation revolved around the perceived role of surgeons amongst doctors themselves. Several oncologists criticized surgeons for misleading patients:

> [...] the surgeons by and large are not a group renowned for their conversational skills shall we say and, you know, it comes down to a degree of interpretation and there are series of stock phrases that patients are given, when they're being referred to an oncologist, which includes things like, 'mopping up rogue cells' and 'having a chat about treatment options' and there are stock phrases to describe surgery as well like, you know, 'the operation went terribly well', which you know, on one occasion was used by a surgeon to describe an open and closed laparotomy because they found lots of tumour they couldn't resect. (onc02, interview)

> The surgeon comes round the next day and says to the patient that the operation was successful. And to the surgeon that means they got in and out without any great upset. To the patient that might mean that the cancer was successfully removed and there's, I think, a big discrepancy and

> understanding there between what the patient interprets in the day or two after their surgery and in what the surgeon has said. (onc05, interview)
>
> But the other thing I was also thinking about was deception in terms of the 'I don't know' when asked a direct question about prognosis, the ones the surgeons do. (onc03, interview)

When the views above were shared with a neurosurgeon, he replied that patients sometimes forget what the surgeon had told them postoperatively or that patients occasionally *pretend* not to have been told anything in order to get a second opinion from the oncologist – an interesting case of deception by patients! (see chapter 8, p.234) Finally, he held a different interpretation of a (neuro)surgeon's role:

> There are three aims in an operation for a tumour and they're very straightforward and simple, and that is diagnosis, decompression and total excision. (neurosurgeon01, interview).

When asked if prognosis was part of the surgeon's role, he added: "Only very broadly. I don't think it's specific, I think that's the remit of the oncologist, largely". The problem, it seems, is that some surgeons and oncologists differ in their views of surgeons' role in information-giving. Since the content of 'truth' in the phrase 'truth-telling' is partly determined by the role of the agent, variations in conceptions of that role will lead to different views on what constitutes an honest disclosure.

Rights and consequences

Truth-telling may be one duty, while acting in a way that would maximize the patient's good may be another. This might explain why some respondents emphasized consequences and patients' 'right to know' in their definition of deception. In the presence of both elements (e.g., if the doctor believes that the patient has a right to know a piece of information *and* that failing to provide it would cause more harm than good), then virtually all respondents agreed that the omission would constitute deception. The level of agreement decreases when one or both of these elements are not perceived to be applicable to the case at hand.

For some respondents, likely consequences played a defining role in labelling an act 'deception':

> An omission is deception if it would materially affect important decisions, but not if it would not. (doc24)

> The consequences have to be bad to the person who would suffer and it depends on that, the degree, doesn't it? (pat11, interview)

> I think not revealing information which you're not immediately going to act on or is going to have no immediate implications is not deception. (onc01, interview)

If the respondents above are right, failing to correct my false belief that the moon is made of blue cheese (even though my expectation to be corrected is reasonable and the speaker thinks my belief is false) may not constitute deception since the information is unlikely to materially affect an important decision. This sounds odd. Whether an act of deception is significant, trivial or inconsequential appears irrelevant to its status as 'deception'. In short, the material consequences of an omission or commission may affect the moral evaluation of the act, but they do not tell us whether an agent was deceiving another or himself deceived.

While some respondents associated deception with moral wrongness by appealing to the negative consequences of the act, others adopted a more deontological approach, anchoring the wrongness of deception to violations of duties or rights. One palliative care doctor, for example, viewed deception as a failure to fulfil a putative duty to impart significant information in the absence of a right to withhold it.

> yes [withholding from Susan is deception] You have potentially life-altering information. I feel it would not be our right to withhold such info. (doc26)

The variability of rights claims

Even if people agree on the existence of doctors' rights and duties that are not based solely on consequences, they may differ in their views of what these rights and duties are. The case of Susan and her father (case 1) provides telling

examples of this. Contrast, for instance, the response of doc26 (reproduced below) to that of another palliative care doctor (doc27):

> yes [withholding from Susan is deception] You have potentially life-altering information. I feel it would not be our right to withhold such info. (doc26)

> no, their relationship is still of father and daughter [...]. I do not have a right to change that relationship unless they indicate to me that they want further information. (doc27)

Both doctors invoked a right, but doc27's right has a different referent. His right presupposes the existence of a duty not to alter something valuable unless asked to. This duty is supposedly stronger than the duty to disclose relevant, important information. Yet the first duty is fraught with pragmatic and ethical problems as it requires 1) a subjective assessment of what is valuable to the patient and 2) a clear violation of patient autonomy in certain circumstances (e.g., when there is a normative expectation of disclosure). Moreover, the corresponding right to have valuable things protected from the interference of others is implausible, or at least needs considerable specification, as we are often forced to abide by laws that may restrict what we consider to be valuable.

Like many other respondents, Doc5 invoked a 'right to know' to explain why withholding information was deception.

> (yes) Because you hold information about someone else which they have some right to know but you are choosing not to tell.

The problem relates to the question: does the patient have a right to know the particular information held by the doctor? As I pointed out in chapter 3 (p.57), the question that follows from the invocation of a right to know is 'a right to know what?'. There is some disagreement about this. For example, an oncologist (onc03) disagreed with doc5 on the non-paternity case: 'I do not think there is a 'right' to know your biological parents -- especially as John obviously thinks he is her father'. One HIV patient believed the patients in case 1 (non-paternity) had a right to find out if their kidney matched but *no* right to know if they were biologically related. A neurologist (neuro1, interview) talked of the importance of "sharing your own clinical uncertainty of [sic] the patient in an honest and open way", thereby suggesting that patients also have a right to know of a doctor's

uncertainty. But at what level of uncertainty is the doctor required to share his doubts? Again, these varying views are consistent with my interpretation that people decide whether a doctor's act is 'deception' based, in part, on their understanding of the role and responsibilities of doctors.

One respondent, a consultant oncologist, acknowledged that patients have a right to know but pointed to the occasional difficulty of respecting that right while maintaining hope, which may also form part of a doctor's duty. In answer to the question 'Has this questionnaire affected your views on truth-telling and deception in medicine', she answered:

> Yes, [it] made me think a lot. I do believe that people have the right to know the truth if they wish, but it can be very difficult discussing things realistically without removing all hope. (onc07)

Does this mean that the right can be overridden or that the scope of the right does not extend past a certain level of detail? In other words, if the doctor gives the gist of the truth, is he respecting the patient's right? This is another way in which people may agree on the existence of the right but differ in their interpretation of it.

In case 5, one patient also acknowledged the patient's right to know but suggested overriding that right on humane and consequentialist grounds:

> Even though the patient does have a right to know the situation, they are already having to deal with a serious medical condition which is out of their control. I don't see the benefit of worrying the patient further, if anything this could possibly worsen their condition. (pat7)

Even if we could establish the existence of relevant rights, we would still need to decide on the scope and weight of those rights. The respondents' diverse and conflicting comments are consistent with my analysis in chapter 3 that rights-based theories require additional criteria to justify a) the validity of a particular right b) whether or not it applies in the circumstances and c) if it does apply, how much weight it holds in the moral evaluation in relation to other moral concerns.

The relevance of relevance

The answer to the question 'the right to know what?' can be analysed under the general category of relevance. Under most accounts of deception, deception requires *relevant* information to be withheld or in some way distorted:

> I believe for deception to occur they must be led to believe something that is known to be false and that thing must be appropriately relevant in some vague sense. (pub1)
>
> It [the information] isn't medically relevant. (pub27)
>
> My gut feeling in this case is that this information [withholding fact of non-paternity] is not relevant and to let sleeping dogs lie. (doc3)
>
> I understand deception as 'deliberate misleading'. Not to tell her info that the test revealed that was not relevant to the reason for the test being done is therefore not deception. (GP04)

The idea of 'reasonable expectation', so central to the proposed definition of deception in chapter 2, is encapsulated by the notion of relevance. After all, what is reasonably expected must somehow be relevant. The opposite, however, is not true: what is relevant need not be reasonably expected. There may be several reasons for this, such as 1) the speaker may have no obligation to disclose the relevant fact (e.g., a surgeon disclosing the type of knot used in suturing) 2) the speaker, for good reasons, may not know about a relevant fact (e.g., the virus that causes the disease is not yet identified) or 3) revealing the relevant fact would entail an unreasonable personal sacrifice for the speaker (e.g., a magician revealing a relevant but professional secret to the heckling spectator).

As some relevant facts can be reasonably expected to be communicated, disagreement over the relevance of certain information may have repercussions on the categorization of an act as 'deception'. The reasoning might go as follows: if a fact is not relevant to Smith, it is unreasonable for Smith to expect this fact to be disclosed and, if there is no such reasonable expectation, omitting to disclose the fact cannot be deception.

Case 1 of the questionnaire illustrates the possible disagreement over whether a particular fact is relevant.* Some believed that the (accidentally discovered) biological non-relatedness of the donor and recipient was irrelevant to the purpose of the test, whereas others believed it had potentially life-altering implications and was therefore highly relevant. I believe the disagreement stems from different referents of relevance. The non-relatedness is indeed irrelevant to the tissue compatibility of the donor and recipient (in this particular case), which was the primary -- and arguably only -- purpose of the test. It is, however, clearly relevant to the patients' lives as it might alter their self-concept, their perceptions of each other, and perhaps even their decisions about the operations.

There thus seemed to be a division among the respondents over which sense of relevance they employed:

Sense 1: relevance of biological relationship to the *medical possibility or success of organ transplantation* between two individuals.

Sense 2: relevance of biological relationship to the *patient's decision* to donate an organ.

Doc15, for example, wrote 'I do not think the lack of a biological relationship is relevant clinically'. In the sense of clinical feasibility and outcome of the operation (**sense 1**), non-paternity is irrelevant. In a broader sense, however, the information *is* clinically relevant since if she donates the kidney she will (probably) improve the recipient's health and endanger her own and, if she refuses to donate, she may maintain her health but the recipient's health will not be benefited. In this broad sense, there are clinical implications either way and the non-paternity *is* consequently relevant (**sense 2**).

Appealing also to **sense 2**, doc26 and pat25 point to the possibility of Susan worrying about contracting the same kidney disease as her 'father' or passing it on to her children. Telling her that she is unrelated might alleviate her fears.† Other

---

* A detailed commentary on an expanded version of case 1 is provided in appendix H (p.359)[270].

† Though of course her fears could also be successfully dispelled without revealing the non-paternity: "you'll be pleased to know that you have not inherited the genes for polycystic kidney disease!".

comments affirming the relevance of knowing about the non-paternity were also made:

> [yes, it is deception] Because the doctor is in possession of information which may be of significant benefit to Susan and John in some future situation. (pub24)
>
> Because Susan thinks she is giving her kidney to her father. (GP10)
>
> By donating a kidney to her father Susan could put her own health at risk, therefore all information should be presented before a decision is made. (pub30)

Flexibility of respondents' definition of deception

In general, respondents who believed an act was morally right were -- unsurprisingly -- less likely to view that act as 'deception' than respondents who considered that same act as morally wrong. When the duty not to deceive patients clashed with the duty to protect patients from harm, two strategies were used to resolve or avoid the apparent conflict. These were:

1. Manipulating the definition of deception
2. Altering the moral acceptability of deception

Manipulating the definition of deception

This strategy entailed altering the definition of deception to avoid an overt violation of the duty not to deceive. This definitional flexibility was reflected in the language used to define 'deception'. For example, two doctors used the adjective 'strictly' to delimit the scope of deception:

> Not answering a question directly [...] is not *strictly* deception. (doc31)
>
> I might stop there because I haven't told an untruth *strictly*. (GP1, interview)

Various patients also appeared to use malleable definitions of deception:

Interviewer: Okay, do you think not telling them is a form of deception?
Patient4: It's another hard one isn't it, I suppose *in a way* it is.

Interviewer: The answer to the question, should doctors ever deceive their patients in their best interests, your answer would be, what? [...]

Patient1: I think sometimes they [doctors] have to be [pause] I'm not happy with the word 'deceive', it's so much like lying, there must be a gentler word than deceive. I'd have to think about that.

To further illustrate how the label 'deception' can be manipulated to suit one's moral preference, one patient (pat20) claimed that withholding information from Susan and her father in case 1 was not deception since 'non-disclosure is not deception'. In case 5, however, the same respondent claimed that not informing the patient of a 40% chance of dying on the waiting list *was* deception. A plausible explanation for the discrepancy is that the respondent is in favour of withholding information in case 1 but not in case 5.

Altering the moral acceptability of deception

While one strategy was to adopt a flexible definition of deception, another was to accept that some deceptions are morally acceptable. The diagrams below show two visual representations of the perceived relationship between moral wrongness and deception. Figure 6 represents the absolutist position on deception, which views all acts of deception as morally unacceptable. Figure 7 illustrates a non-absolutist view, which permits some acts of deception.

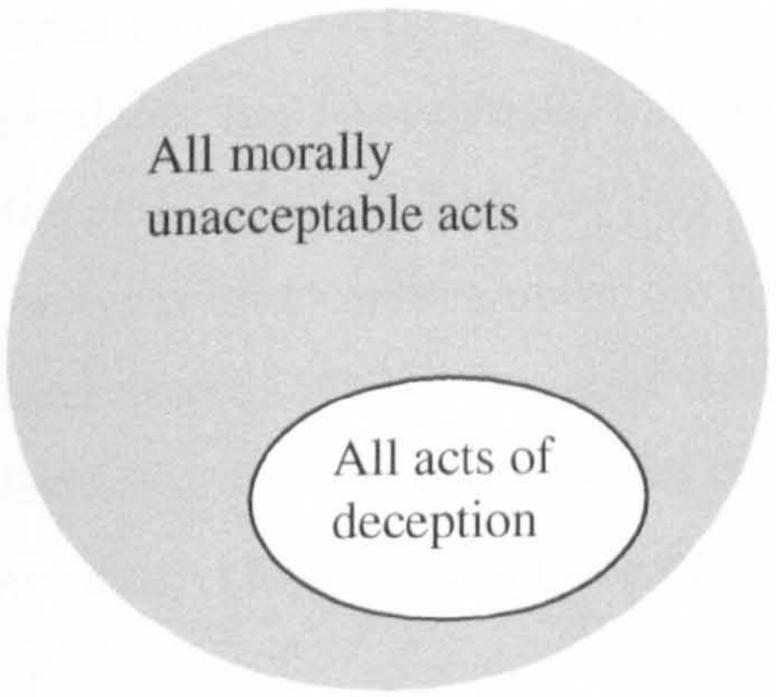


Figure 6 (absolutist position)

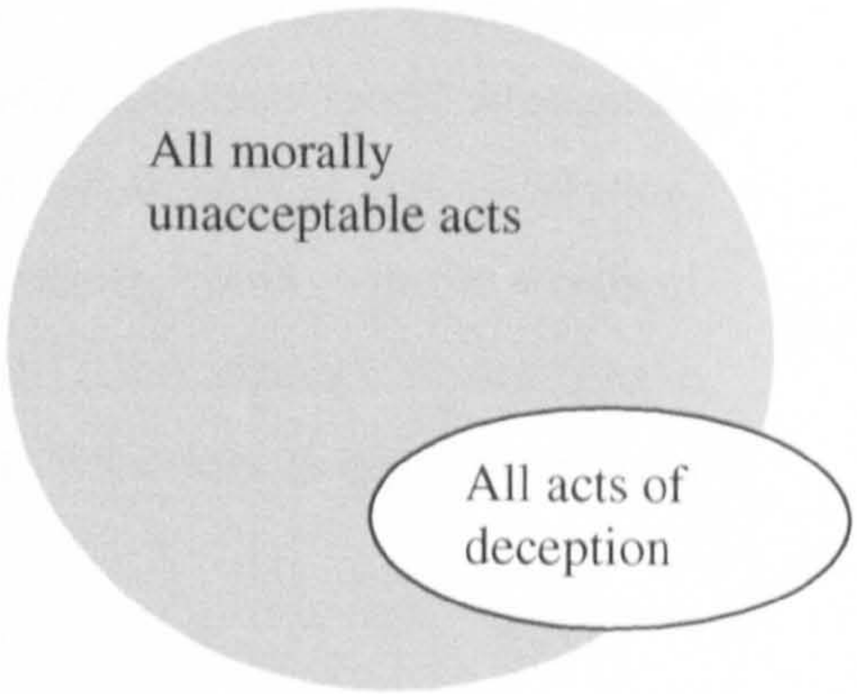


Figure 7 (non-absolutist position)

Figures 6 and 7: two visual representations of the perceived relationship between deception and moral wrongness

As mentioned earlier, some respondents appeared to shift from one view to the other depending on the situation:

> To a certain extent [the interview has changed my mind] because I would have said in the first place 'yeah, deception is always wrong', but you've pointed out situations where it might be in the patient's best interests but, you know, I'm still a bit bothered by it. (pat10, interview).

> Until I read your questionnaire I did not think that there would be any occasions when I would lie to a patient in answer to a direct question! But the situation of the dying patient (one I thankfully haven't faced) I thought was one (onc06)

> My perception of what is a lie has changed -- I think it should include omissions. I have realised that my view that doctors should never lie was too absolutist and my views have therefore shifted somewhat. (doc11)

These comments might reflect a move from a view represented by figure 6 to one that most resembles figure 7.

The extracts above highlight both the importance of definition on one's views on the moral acceptability of deception and the difficulty of using the term without a clear, mutually understood definition.

The questionnaire and interview as reflective exercises

It was not unusual, by the end of the questionnaire, for respondents to say that the exercise had altered their views on the acceptability of deception. Whereas some respondents may have initially linked deception with necessary moral wrongness, by the end of the questionnaire they had loosened the strength of that association. Some types of deception, under the right circumstances, could -- in the words of an interviewee (pub9) -- be 'good deception'. Pub11, for instance, wrote 'I have realised that there are cases when I think deceptive behaviour is appropriate and I have a clearer idea of when those cases occur'.

The key word is 'clearer'. Many of the respondents, although clearer, were still uncertain about the definition and acceptability of deception. They commented on how they found the questionnaire thought-provoking. Since the scenarios were developed and selected for their ethical difficulty, this was to be expected.

Some respondents seem to have grown *more* uncertain by the end of the questionnaire. One consultant pathologist commented that the questionnaire revealed to her 'that matters are more complex than I thought'. This was echoed by a member of the public: 'It [the questionnaire] makes me realise that this topic is not as straightforward as one might think'. (pub2). Other typical comments include:

> not sure what I think now about the distinction between lying and withholding info, that is if there is a distinction at all. (pub5)
>
> It made me think about the distinction between deception and lying. I'm still not sure exactly where I stand though. (doc9)
>
> Yes, previously viewed only lying directly as deception -- will now think more carefully about other forms. (doc17)

The uncertainty of many respondents was apparent in the conflicting natures of some of their responses. Onc05, for example, claimed that 'hiding the truth is the same as a lie' and that consequently lying is not morally worse than other forms of deception. Yet, in the case of Mr Smith, she asserts that it would be preferable to deceive Mr Smith without having recourse to a lie. Although not *necessarily* a contradiction (for example, onc05 might believe that they are morally equivalent but, due to the popular perception of lying as worse, it is preferable for pragmatic reasons to avoid lying), it may well be.

The sometimes chaotic nature of the data, represented by the contradictions, pauses, hesitations, and overt expressions of uncertainty, reflects respondents' difficulty in articulating their views and reasoning on the concept and acceptability of deception. Many had not pondered on this question prior to the research. Their moral reasoning took place during the course of the questionnaire or interview itself, which may explain why so many people changed their minds by the end of the exercise. This raises a question about whether we can be confident that the data mirror the deeply held beliefs of respondents or whether they are merely the product of ad hoc and unreflective reasoning. This is a methodological observation that can be generalised to other applications of qualitative research to complex ethical issues. Qualitative methods may capture the process, content and result of ethical reasoning but how deliberated these are

can be difficult to assess. The qualitative researcher should surely acknowledge this uncertainty in his interpretations.

Relevance of defining deception

The empirical findings indicate considerable uncertainty and disagreement over what constitutes deception. This reflects the definitional variations in the published literature on deception and echoes my own struggle to find a satisfactory definition of the term (see chapter 2). Respondents also differ in what they mean by 'telling the truth'. What one doctor believes is 'telling a patient the truth about his condition' may be considerably different from what another doctor thinks is telling the truth, depending on their interpretation of what constitutes 'relevant' information in the particular circumstances and their perception of a doctor's role and responsibilities. One doctor may believe that 'telling the truth' requires a discussion of prognosis, for example, whereas another may believe that disclosing the diagnosis and treatment options is sufficient. Furthermore, inconsistencies among the responses of individual respondents were also common.

So what can be concluded from this, apart from the observation that defining deception creates widespread uncertainty, if not outright confusion? It seems that, although people often find it hard to separate deception from moral wrongness, most acknowledge that deception, even by their own definition, may also be morally acceptable in some circumstances. For this reason, whether an act is considered deception is not sufficient to ascertain the overall moral status of the act. Rather, the moral status of the act -- deception or not -- is context-dependent. The consequences of the act, the motives behind it, the listener's expectations and values, and the situation in which it occurs affect the rightness or wrongness of the act far more than its classification as deception. If the *only* fact given about an act X was that it constituted deception, there would be no way to establish with certainty whether X, all things considered, was morally good or bad. We could say, however, that it was *probably* wrong due to the prima facie wrongness of deception. That would be a good bet, but the prima facie nature of deception means that it might have been morally desirable in this particular case.

The empirical findings strengthened my theoretical view that the strong emotive force and negative connotations of the term 'deception' render the concept distinctly unhelpful, at least in morally unclear cases. The finding that respondents are more likely to label acts of which they disapprove 'deception' points to an unstable definition prone to bias and perspectival change. Often, saying that an act is deception is little more than expressing a disapproving attitude towards that act, rather than providing a substantive reason for its undesirability. The use of the term can be used as a shortcut to condemn the act without elaborating on the reasons for its alleged moral wrongness.

Implications of a definitional analysis of deception

So what practical and philosophical implications can we derive from the data? In the face of considerable disagreement over a definition of deception, and the strong negative connotations associated with the term, it might be preferable (at least in morally contentious cases) to substitute 'deception' with a clearer, less morally loaded description of the act or omission in question. For example, instead of asking 'is it morally acceptable to deceive a dying cancer patient?', it would be more informative to ask 'is it morally acceptable to withhold bad news from a dying cancer patient, to impart bad news in a euphemistic or indirect manner, or to tell a direct untruth about his condition?' This phrasing is more conducive to moral analysis and rational debate than one which includes the vague and disputed term 'deception'. It avoids the need to untangle the concept of deception.

Similarly, the bioethical discourse on truth-telling should broaden the scope of its concerns beyond whether telling the truth is right or wrong to epistemological questions about what the relevant truths are. Only when those truths have been clarified -- and such clarification is dependent on context -- can we sensibly address the normative questions. Doctors are not required to disclose all truths, but merely relevant truths that patients could reasonably expect to be told. Truth-telling, in itself, is normatively neutral. Mindlessly uttering true but irrelevant statements alone in a sound-proof room is neither morally good nor bad. Truth-telling becomes morally significant only when transposed into a clearly defined

context. More straightforwardly, before asking "should the doctor tell the truth to his or her patient?", we need to determine what the relevant, available, and reasonably expected truths are in the circumstances. As the non-paternity case demonstrates (case 1), what qualifies as such a truth is not always obvious or agreed. Pat47, for example, wrote that 'the truth is that Susan is a suitable donor. All else here is irrelevant'. For many others, there were other relevant truths. And even when a reasonably expected truth is established, it may still be unclear whether or not it should be disclosed.

The 'truth' in the phrase 'tell the truth' represents a particular point of view, situated in a specific context, and requires justification. Take, for example, the real case presented by an oncologist (onc03) of a patient who attended a consultation believing her metastatic cancer was curable. Although the oncologist estimated her survival to be three or four weeks, she told the distraught patient that she had 'months' to live. The oncologist considered this overestimate to be a form of deception. According to her, she did not tell her patient the 'truth'. When the case was recounted to her oncologist colleague, however, he commented:

> Basically he [the colleague's gender was changed to protect confidentiality] didn't lie there at all. He *simply told her the truth* and when she was very upset he sort of modified the estimate, but he's already told her the truth.(onc04, interview) (emphasis added)

For onc04, the 'truth' was not an accurate translation of what the oncologist believed (i.e., a few weeks left) but simply getting the patient to come to "some realistic level". Presumably, for that oncologist, modifying the estimate by a few weeks did not alter the realistic level sufficiently to warrant the term 'deception'. This case highlights the differences in people's views about what constitutes 'telling the truth' and reinforces the idea, introduced in chapter 4, of disclosure as an idiosyncratic translation (see p.81).

The subjective element in the construction of the 'truth' in the context of truth-telling in medicine is made clear by the comments of another oncologist (onc05, interview) and a neurosurgeon (neurosurgeon02, interview):

> I think that most oncologists tell the truth to be honest. Now then, the truth differs from one patient to another depending on what amount of information *you...they think...you think* they can manage and that kind of thing. (onc05) (italics added)

Onc05 seemed to hesitate between 'you' and 'they' in the extract above but the point here is that he acknowledges that the 'truth' will vary depending on the judgements and expectations of the doctor, the patient or both.

Neurosurgeon02 recounted a situation where he realised that a colleague had incorrectly performed an operation, removing the fluid surrounding the brain tumour rather than the tumour itself. The interviewee said to the patient:

> "Look I'm sorry I don't think that enough has been done for you and we need to do more" and I went through the risks associated with that and got on and dealt with it and took the tumour out. So I've been honest with them.

When asked if not telling the patient about his colleague's mistake was deception, he replied:

> No I, I think I'm just being honest. I mean I don't want to generate bad feeling, I don't want to generate litigation and, and that's what that does.

Again, one person's self-ascribed honesty is another man's deception. The patient may well have disagreed with the neurosurgeon's assurance that he was being honest.

The empirical findings about people's understanding of deception, and in particular their uncertainty about the concept of deception, suggest a need to step back from the normative question. The epistemological question about what the truths are should logically precede the normative question about whether these truths should be disclosed and the pragmatic question about how it should be told.

I have so far distinguished three main questions in the issue of truth-telling:

1. What are the relevant, reasonably expected truths in the circumstances?
2. Should those truths be revealed?
3. How should they be revealed?

Although I have separated 1 and 2, they are interrelated. A search for the relevant truths will rest on evaluations of what is relevant based on normative beliefs. R.M. Hare, in his essay entitled *Relevance*, writes:

> It is a great mistake to think that there can be a morally or evaluatively neutral process of picking out the relevant features of a situation [...] when we decide what features of the description are morally relevant, we are already in the moral business[271](p.193).

In the non-paternity case of the questionnaire (case 1), for example, I earlier described that we could argue either that the information *is* relevant since it is necessary to make a properly informed decision or that it is *not* relevant since the patients did not ask for that information. The first argument is premised on the belief that patients *should* be allowed to make properly informed decisions. This is a normative claim that underpins the evaluation of the act as relevant. The non-paternity is relevant *because* it may affect the patient's decision. If we keep on asking 'why does it matter?' (e.g., why should the patient's decision be respected?), we will arrive at a fundamental, normative claim, perhaps on the intrinsic value of respecting the autonomy of rational agents.

Similarly, the second argument (against relevance) might rest on normative assumptions regarding the limited scope of consent and, again, the value of respect for patient autonomy. The non-paternity is irrelevant, the argument might go, because the patients did not ask for the information and disclosing the fact without their explicit consent would fail to respect their autonomy. So, whatever the position taken on the relevance of the information, some normative element will have contributed to the decision to label the information as 'relevant'.

The conclusion from the above is that there can be no fact/value distinction when discussing *relevant* truths in the context of truth-telling in medicine. The very identification of a truth as 'relevant' is the product of a value judgement, although that judgement may be so embedded in socially accepted practices as to be unrecognised.

Despite the normative underpinnings of the answer to question 1 (*what are the relevant, reasonably expected truths?*), the answer to 2 (*should they be disclosed?*)

still needs to be resolved. The answer to 1 usually occurs at an intuitive level and may not possess sufficient motivational force to resolve 2, whose answer will be based on more explicit forms of reasoning. Once identified, a relevant, reasonably expected truth inevitably plays a part in the moral evaluation of an act of disclosure or non-disclosure. It does not, however, resolve the issue. Even if a fact has been established as relevant and reasonably expected, the agent may still decide to withhold it for other reasons. The nature of these reasons, as identified by respondents, and their relationship with the perceived acceptability of deception will be the focus of the next chapter.

CHAPTER 8

Acceptability of Deception in the Medical Context

After establishing that there is much variation in people's understanding of deception, I now turn my attention to the moral acceptability of deception, however conceived. In short, 'are doctors ever justified in deceiving their patients and, if so, what sorts of justifications might be given to support this position?'. The unstable semantics of the concept of deception highlighted earlier do not present an insurmountable problem if I rely on respondents' own definitions. This would allow me to conclude that, whatever their conception of deception, people believe that it is acceptable to deceive in situations A, B and C for reasons X, Y and Z.

Contradictions and modified results

In response to the first part of the question above ('are doctors ever justified in deceiving their patients?'), the table below shows the overall percentage of survey respondents and interviewees who explicitly stated that doctors would be morally justified, in some circumstances, in deceiving their patients.

	YES (non-absolutist)	NO (absolutist)
Doctors (n= 99)*	75%	25%
Patients (n=98)	64%	36%
Members of the public (n=63)	83%	17%

Table 5: percentage of survey respondents and interviewees who stated that doctors' benevolent deception to patients may sometimes be morally justified

Although it is important to reiterate that this is not a quantitative study and hence that the figures are not statistically significant, it is clear that in each of my respondent groups a majority adopted a non-absolutist position on doctors' benevolent deception, while a minority claimed that such behaviour is always wrong. Before I embark on a search for an explanation, it is worth adding that some respondents who answered 'no' to the survey question 'Do you believe that

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* In a few cases, it was not clear whether an interviewee held an absolutist or non-absolutist view on this issue. The numbers in brackets indicate the number of respondents and interviewees whose views on the matter could be clearly ascertained from the data. Again, the results are not statistically significant but are merely indicative of quantitative information.

it is ever acceptable for doctors to deceive their patients?' nonetheless appeared to condone, or even encourage, deception (as defined by the respondents themselves) in earlier parts of the questionnaire. Three GPs (GP1, 23 and 31) and two patients (pat35 and 49) who answered 'no' to the question above believed that the doctor in case 1 (non-paternity case) should withhold the information about the non-paternity whilst affirming that a failure to disclose this information constituted deception -- a clear contradiction. One intensive care registrar (doc14), two other patients (pat9 and 31) and two members of the public (pub25 and 47) answered that benevolent deception is always wrong, but in case 6 opted not to tell Mr Smith about his cancer diagnosis and labelled this 'deception'. If I assume that the respondents who opted for a deceptive option (using their *own* definition of deception) in a hypothetical scenario are in favour of at least some benignly intended deception by doctors, then the results in table 5 would be modified as below:

	YES (non-absolutist)	NO (absolutist)
Doctors (n= 99)	79%	21%
Patients (n=98)	69%	31%
Members of the public (n=63)	86%	14%

Table 6: percentage of survey respondents and interviewees whose responses indicate that doctors' benevolent deception to patients may sometimes be morally justified

This revised table slightly narrows the gap between the groups and indicates more clearly the widespread agreement amongst my respondents that doctors' deception is sometimes morally acceptable. The dictum of the American Medical Association's Principles of Medical Ethics which states that doctors should be 'honest in all professional interactions' is thus rejected by a significant majority of the respondents in my sample[131]. The cases of contradiction also demonstrate, as shown earlier, that some people have inconsistent beliefs about the morality of deception.

Explaining differences

Differences regarding the acceptability of deception do not necessarily result from fundamental differences in belief but also, as I argued in the preceding chapter, from people's diverse understandings of deception. For example, two self-

proclaimed 'absolutist' oncologists disagreed about whether withholding information about a 40% death rate to the heart transplant candidate (case 5) was 'deception'. For a respondent with a broader definition of 'deception', most of the self-proclaimed absolutists against deception are not really absolutist, since some of their answers are, by *his* definition, 'deception'! In short, the 'absolutist' label does not provide a clear account of which acts are permitted or forbidden by the agent.

Despite the definitional confusions about deception and the term's strong negative connotations, the majority of respondents believed doctors' deception to be acceptable in certain circumstances. So what reasons did they give to support the acceptability of deception? Again, I constructed a qualitative model to examine the relationships between the relevant codes. The model is reproduced below (see next page):

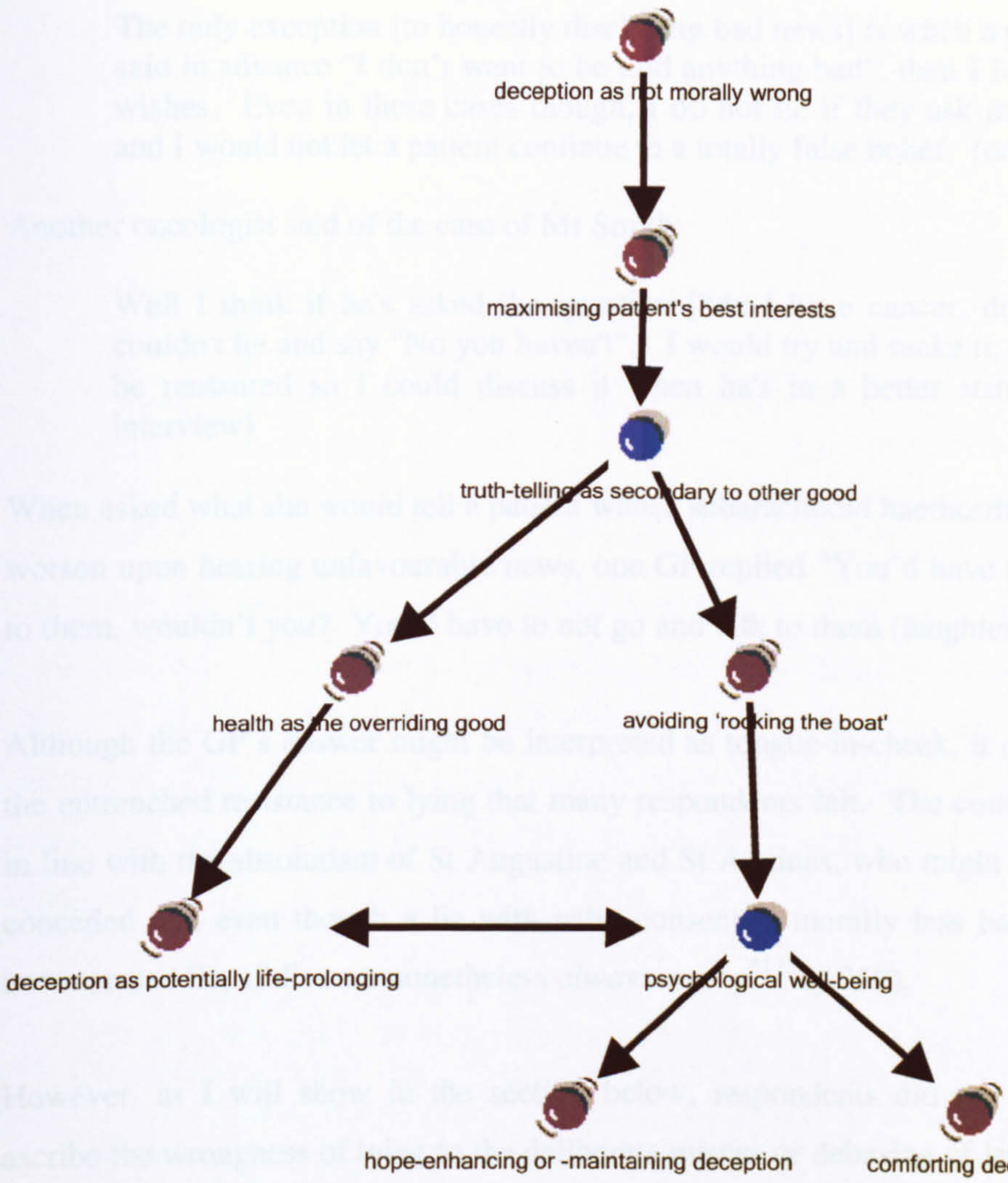


Figure 8: model showing the relationship between codes pertaining to the moral acceptability of deception*

Absolute positions and their rationales

Whilst the majority of respondents favoured some forms of benevolent deception in certain circumstances, several respondents adopted an absolutist position on the wrongness of lying and, to a lesser extent, deception (under their own understanding of the terms).

For example, even if a patient declined all bad news prior to the test, onc05 would still avoid a lie if asked directly:

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* I examine some of these codes in detail in my analysis of the functions of deception in chapter 9.

> The only exception [to honestly disclosing bad news] is when a patient has said in advance "I don't want to be told anything bad", then I follow their wishes. Even in these cases though, I do not lie if they ask me directly, and I would not let a patient continue in a totally false belief. (onc05)

Another oncologist said of the case of Mr Smith:

> Well I think if he's asked the question ["do I have cancer, doctor?"] I couldn't lie and say "No you haven't". I would try and make it, get him to be reassured so I could discuss it when he's in a better state. (onc04, interview)

When asked what she would tell a patient whose subarachnoid haemorrhage might worsen upon hearing unfavourable news, one GP replied "You'd have to not talk to them, wouldn't you? You'd have to not go and talk to them (laughter)." (GP01)

Although the GP's answer might be interpreted as tongue-in-cheek, it does show the entrenched resistance to lying that many respondents felt. The comments are in line with the absolutism of St Augustine and St Aquinas, who might well have conceded that even though a lie with valid consent is morally less bad than an unconsented lie, all lies are nonetheless *always* wrong[51 55](p.257).

However, as I will show in the section below, respondents did not explicitly ascribe the wrongness of lying to the deliberate misuse or debasing of language or to the self-distancing from God, as St Augustine and, more recently, Geach have suggested[272 273].

Perceived moral differences between lying and non-lying forms of deception

It is perhaps unsurprising that absolutism about lying was more common than absolutism about deception *tout court.* What explanations emerged for this difference?

Many respondents struggled to provide reasons for their hostility to lying. One patient with endometriosis said "I just have a bit of a moral thing about lying. I don't like it". (pat9, interview)

Others managed to articulate some reasons for their distaste. One GP described why he believed lying to be worse than other forms of deception:

> It's because of what will come back to you, the fact that you will have another discussion with them. You may say something to a patient that may be a bit of a fudge and you can come back to that and re-open it and say oh well, we weren't sure but perhaps we should talk more about it. But if you said no and you meant yes, they can always...they're always going to know. The information may well be in the domain between the two of you at a later date and they'll know, they'll understand that this was not true and it will break the relationship for ever. And if they don't know, well that's still, you know, an underlying dissonance -- you lied to them!

One oncologist (onc02, interview) initially based her disapprobation of lying on her upbringing: "I was brought up not to lie, you know, lying was just never an option, so that's something I wouldn't ever entertain". This appeal to an early inculcation of the wrongness of lying was mentioned by many respondents. The oncologist then elaborated on why lying to a dying patient about prognosis is wrong:

> You're digging yourself a hole that's going to be worse to get out of. They're not going to believe you again if you're so clearly incorrect in some of the things that you confirm incorrectly if you like, you lie about, but the patients sort of, they put a huge amount of trust in what you say to them and if they realise that you've actually lied to them then, I mean okay in that situation they're only going to realise that you're wrong as they're dying so, but it's still going to be a horrible realisation to them, I think.

Based on various comments by respondents, the reasons why lying is considered worse than non-lying deception can be summarised as follows:

1. The belief that 'lying is wrong' was inculcated in childhood and has persisted to the present day
2. Lying creates problems that are difficult to rectify and may require further lies
3. Lying will reduce the chances of the patient believing what you say in the future
4. Lying is a breach of the trust put in you by the patient
5. The categorical nature of lying, unlike non-lying deception, does not provide patients with the opportunity to unearth the information in other ways (e.g., through further questioning)
6. The discovery of the lie can be deeply distressing for the patient

The GP's mention of the 'underlying dissonance' even if not 'caught' by the patient is interesting. Dissonance contrasts with harmony, which in this context can refer to two relationships:

a. Harmony between the doctor and the patient, of which trust forms an important part.
b. Harmony between the multiple roles of the doctor, in particular the doctor-as-professional and doctor-as-moral-agent.

Lying can disrupt both a) and b) by, first, instilling dishonesty into the doctor-patient relationship and, second, making the doctor violate a deep-rooted belief, often acquired in childhood, that lying is wrong. The philosopher Arnold Isenberg suggested that lying exhibits 'a character that is probably *symptomatic* of further disvalue and of moral delinquency'[102](p.479) (his emphasis). And indeed, many respondents seem to have made a strong association between the symptom (the lie) and a deficient moral character. This association between lying and moral deficiency is hard to articulate and people may not be consciously aware of it. It may underlie, at least partly, the justification given by several respondents that lying is wrong because it "just is".

Interestingly, the association does not appear to be as strong between non-lying deception and moral deficiency, although some respondents believed otherwise. The survey results (see table below) suggest that doctors have a greater aversion to lying than other forms of deception, although of course caution must be exercised when interpreting the figures.

Qu.20 Would you generally feel more, equally, or less comfortable lying to a patient than using other forms of deception? (e.g., being economical with the truth, being vague or not answering the question directly)	%
More comfortable lying	1 (n= 1)
Equally comfortable lying	4 (n= 3)
Less comfortable lying	**87** (n= 71)
I don't know	9 (n= 7)

Table 7: doctors' questionnaire results for question 20

An unexpected evaluative difference between the groups

An unexpected finding from the research is that patients were more likely to view lying and non-lying deception as morally equivalent than other groups.* The most common explanation for the equivalence was that both methods produce the same end result. One patient (pat18) argued that both were aimed at preventing the patient from accessing the truth, while another patient (pat9, interview) said that, in some cases, they 'insinuate' the same false belief. The difference between patients and other groups may be explained by the greater and more immediate reliance of patients on doctors' honesty, as well as their physical and psychological vulnerability resulting from illness. This vulnerability could prevent them from constantly questioning the doctor and astutely perceiving different forms of deception or information control.

These results run counter to Jackson's claim that lying is a greater breach of trust than non-lying deception, at least from these patients' perspective[6 10]. Just over half of the patients who responded to the questionnaire believed non-lying deception to be as bad as lying. However, the findings do lend support to Bok's assertion that there are likely to be perspectival differences between the moral evaluation of a lie between the liar and the deceived[9](p.28). Whereas non-patients generally considered lying to be morally worse than non-lying deception, patients in my research generally viewed them as morally equivalent.

There is some empirical evidence that the moral acceptability of forms of deception is heavily dependent on context, rather than on any intrinsic criteria. In the final question of case 6 ('would it matter if the doctor deceived the patient [Mr Smith] by lying or if he deceived him by others means, such as cleverly answering a different question?'), just over half of doctors and members of the public believed both methods to be morally equivalent (compared to 59% of patients). This is in stark contrast to their answers to the later question, asked in isolation,

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* Thirty nine percent (39%) of patients I surveyed believed that lying about important information was morally *worse* than withholding important information. In contrast, 60% of the 'public' respondents believed that lying was worse, and 77% of doctors considered lying to be morally worse than other forms of deception. However, the different formulation of the relevant question in the 'doctor' questionnaire may have affected the results. For an account of this methodological limitation, see p. 292.

about the respective acceptability of lying and non-lying deception, which revealed a general agreement amongst doctors and members of the public that the former is worse than the latter. The results of the Mr Smith case suggest that many respondents shared Bernard Williams's view that, in some contexts, 'it makes no difference whether deceit takes the form of lying or of something else'[35](p.108). The results also lend empirical support to Robert Veatch's position, which is that lying and concealment are morally equivalent when the doctor holds a duty to tell the truth[154](p.226). The results of the direct question about the relative badness of forms of deception, asked in isolation at the end of the questionnaire, arguably indicate the stronger, probabilistic link between lying and moral wrongdoing rather than any intrinsic moral differences between deceptive forms.

The case of Mr Smith

Of all the scenarios, deception was most recognised as acceptable in the Mr Smith case (case 6). An examination of the answers of doctors who a) opted not to tell Mr Smith of the cancer and b) conceded that this omission was deceptive should help isolate the factors which made deception acceptable for the respondents.

One neurosurgeon (doc3) writes that treating Mr Smith's heart condition is a 'greater need'. The use of the comparative suggests that truth-telling is also a need, but one that is not as urgent or weighty as the need to prevent another heart attack.

Doc5 talks of weight in terms of risks and benefits, as opposed to need. These consequentialist approaches view the moral acceptability of deception as dependent on likely outcomes. One interviewee (pub9), a 75-year-old woman, also highlights the importance of consequences in evaluating the acceptability of deception, but suggests that the deceptive act must also be made in good conscience. A good deception, then, is 'good' in two ways:

1. It has good consequences, and
2. It is made with good intentions

What most of the responses show is that truth-telling was, at times, considered of less importance than other moral goods, such as health or psychological well-being (see figure 8, p.203). The justifications for deception highlighted the second place of truth-telling over other desirable outcomes:

> The decision should be based on the clinical information available -- how long till Mr Smith's blood pressure is under control? How quickly does the cancer need to be treated? What are the chances of another heart attack? The doctor should tell Mr Smith as soon as it is safe to do so. (pub11)

> It would cause more harm than good at this stage. (pub17)

> It may harm him. He is not going to start treatment until he is over his MI [myocardial infarction] anyway. (derm1)

> At that moment in time it is in the patient's best interest to make a full recovery from his MI first. (onc03)

The dangers of deception

Aside from any intrinsic wrongness associated with the act of deception itself, deceiving patients was deemed undesirable for four main reasons. The first relates to the autonomy-restricting effects of deception; the second to the psychological distress that deception can trigger; the third to the lax attitude to deception that may result from an initial, permissive position; the fourth to the deterioration of trust associated with deception. The dangers of deception can be subcategorised further.

Deception as preventing adjustment

Even for non-absolutists, benignly intended deception can be as damaging as truth. One of the most common arguments against deception, both in the empirical findings and in the bioethical literature, is that it violates patient autonomy and, more concretely, prevents patients from adjusting their lifestyle and mental states to match the severity of their condition. This was expressed by one patient:

> I do not feel that I was fully informed about my condition -- and on the basis of the info I was given could not make any kind of informed decision as to what to do about it. (pat1)

Withholding information from a suspecting patient may even aggravate a patient's fear, causing much psychological distress:

> because if they [patients] know they are ill and they fear things, they're always imagining the worst whereas I feel that if you know the worst you can face it much more easily than imagining what may be. (pat5, interview)

Deception as preventing closure

In the case of terminally ill patients, deception which instils or maintains an unrealistic prognostic belief runs the risk of preventing 'closure':

> Patients in the last stages of cancer need to be able to say their goodbyes in a dignified fashion, without unrealistic promises of treatment muddying the waters. (pat5)

Here truth-telling is associated with preparedness, dignity and the reduction of uncertainty. Deception can be psychologically damaging by preventing the patient from experiencing these positive emotions.

Deception as undermining dignity

Pat5's comment also exemplifies how an inability to achieve closure can result in a corresponding loss of dignity. She continued:

> Oncologists must learn to be totally honest: patients need to be able to make wills, see a grandchild, take a last holiday, and not spend their last months feeling sick and losing their hair and dignity. (pat5)

The slippery slope of deception

While deception appears acceptable in cases where truth acquires a functional *dis*value, a failure to attribute it a prima facie wrongness can lead to an overly permissive attitude towards deception. This risk is mentioned in the bioethical literature by Sissela Bok and Jennifer Jackson[69]. A similar point was also made by several respondents, such as neurologist 1 (interview):

> If your starting point is that there are situations in which you think it's ok to deceive, I think you're on a slippery slope to behaving in a way that is paternalistic and wrong.

According to this argument, even trivial deceptions, however morally appropriate they may seem, should be avoided for fear of loosening the inbuilt (and desirable) distaste for deception.

Deception as undermining trust

Finally, an appeal to trust, and its deterioration, was frequently given to justify the moral wrongness of deception and, in particular, lying.

> Lying is a direct breach of trust. When patients ask direct questions they usually expect truthful answers. (onc02)

I discuss the issue of trust in more detail later in the chapter (p.217-222).

Naturally, the dangers of deception listed above could also be viewed as 'benefits of truth-telling'.

The functions of truth-telling

The functional value of truth-telling to patients can be broadly divided into a *choice-promoting* value and a *reality-confirming* value.

Truthful information is choice-promoting in that it often opens up several hitherto unknown or unconsidered pathways of possible action. These new choices, however, do not necessarily lead to greater satisfaction. Truth, as I have already explored, can lead to distress through exposing the patient to a terrifying reality. Various empirical studies have also demonstrated that excessive information can destroy patients' coping mechanisms (e.g., denial)[274 275]. The authors of another study on cancer patients, however, claimed that 'knowledge does not impede the application of selective denial as a protection against hopelessness'[276](p.835).

The truth, surely, is that individual patients will differ in their response to the information.

At times, truth can *restrict* possible choices by revealing constraints. A diagnosis of an aggressive terminal cancer may destroy a patient's dream to travel around the world or to write a novel, for example. It is when these constraints are expected to extinguish a patient's desire to choose subjectively highly valued paths that deception is often deemed acceptable. One patient said:

> If you withdraw hope of any kind that's almost as bad as lying, I think. Myself, I knew I was very ill but if my son hadn't been there saying "come on, come on", you know, "you're going to be all right, you're going to get through", I don't know...I think I was just slipping away, you know. (pat9, interview)

For many respondents, hope-maintaining deception can trump choice-promoting truth when the benefits of hope outweigh the benefits of having new, more realistic choices.

Truth may also be *reality-confirming*. Patients may suspect that something is wrong and imagine a number of possibilities, some of which could even be nastier than the reality. The anxiety caused by uncertainty can be detrimental to a patient's well-being. Pat25 wrote "not knowing is always far worse than the truth". This sentiment was echoed by pat14 and derm1 (interview):

> I have MS and find trying to get the whole truth from medical staff difficult, some things they treat as a guarded secret -- this only adds to the stress as patients usually have a good idea of what is going on in their own bodies and need to be able to trust those caring for them. (pat14)

> Well, I know that situations where people have great anxiety about cancer is sometimes related to not knowing. And directly you know, the anxiety is gone and you'll cope with it better. (derm1)

Other patients will hold on to any glimmer of hope, even if aware that the situation could be far worse. In some cases, confirming a possibility could remove that hope and trigger adverse and irreversible emotional responses.

> At the end of the day, I do not want to be told I'm going to die or I would lose all hope and [this would] make my last days worse. (pat22)

In some patients, there is a clear tension between a desire to know and a desire not to know:

> I was told last year that I have a 40% lifetime chance of my chronic pancreatitis becoming malignant and then, by the time it was discovered, it would be too late to cure it. This is a very real issue for me! Of course, on one level, I would rather not know this. I was happier before! However, the course of my treatment could (and has done, to an extent) change once I have this knowledge. I also take advice on diet, etc. more seriously than I might otherwise have done. (pat10)

Pat10's comment reveals the tension between different emotions and desires. "On one level", possibly an intuitive level, he appears to associate the disclosure itself with his radical change of life. Like in Racine's *Phèdre*, in which the anguished queen confesses her forbidden love for her son-in-law, the uttered words are seen as the harbingers of tragedy[277]. On another, more reflective level, he seems glad to have been told, as this allowed him to take beneficial measures.

Pat10's inner conflict is in line with the findings of Kutner *et al.* and Kirk *et al.*[278] [279]. The former group discovered in qualitative interviews that patients wanted more information but, at the same time, feared bad news. In the qualitative branch of their study, they found that while all respondents wanted doctors to be honest, 91% wanted them to be optimistic[269](p.1349). Similarly, while 80% desired information about the expected course of their disease, only 60% wanted to know their life expectancy[269](p.1346). As the authors observe and the present research confirms: 'This presents a difficult conundrum for health care providers'[278](p.1349). Kirk *et al.*'s interview-based study on cancer patients in the palliative care setting found that some patients 'wanted to be told [about prognosis] but did not want to know'[279]. The authors also note that, even in the final stages, patients and families 'still wanted the door to be left open for the possibility of a miracle'[279]. Both these studies support my observation that many respondents are uncertain or inconsistent about their own beliefs on truth-telling.

Group perspectives on doctors' conflicts of duty

If the duty not to deceive is only prima facie wrong, there will be situations when stronger duties require an agent to deceive. As I discussed earlier, one such

situation, as judged by many respondents, was deceptively withholding a diagnosis of cancer from Mr Smith (case 6). In light of this widespread belief, the findings that I found most surprising related to question 14iii) which asked respondents whether the doctor would be justified in deceiving Mr Smith if asked a direct question about the cancer. The results are shown below:

	YES	NO
Doctors	11%	89%
Patients	16%	84%
Members of the public	30%	70%

Table 8: survey results for question 'If Mr Smith asked a question which could only be truthfully answered by telling him that he has cancer, would the doctor be justified in deceiving his patient?'

Why did respondents agree to deceptively withhold information from Mr Smith on health grounds but not to deceive him on identical health grounds? One GP (GP21), for example, wrote that withholding information from Mr Smith would be acceptable because 'honesty that directly risks killing the patient [...] does not balance beneficence with non-malevolence', yet, in a later question, he wrote that deceiving him if he asked a direct question would *not* be acceptable. Why would the justification above not also apply in this case? As this question was not answerable from the questionnaire itself, respondents who left their contact details were contacted again and asked for reasons for their answer.

In a clarificatory e-mail on the Mr Smith case, one member of the public wrote:

> In this instance, I think it would do the patient best to not know about the cancer at the moment. However, I would find it difficult for the doctor to tell an outright lie if the patient asks a direct question about it. It would probably be better for the patient not to know, but I think the doctor has a duty to tell the truth here, even though it may be worse for the patient. I'm sure my argument is somewhat contradictory here, but then every case on its on merit! Best if the patient doesn't ask. (pub42)

Couched in language conveying reluctance, pub42 anchored his justification on the doctor's 'duty to tell the truth'. This duty apparently trumps considerations for the patient's well-being. Judging from the survey results of the Mr Smith question above (≈ 90% against deception) and of case 4 (doctors accidentally administers fatal dose), where over half the doctors chose to disclose the error, it appears that

deontological reasons can sometimes override consequence-based considerations. The most popular justification for the disclosure in case 4 was 'You feel the doctor has a duty to be honest to the patient about his/her mistake'.

In that same case, only 40% of patients believed the patient should be informed of the fatal error and the most popular justification for non-disclosure was 'The doctor should not wish to make the patient's last moments more painful than is absolutely necessary'. This is an intriguing contrast, as it suggests that the common belief that doctors are utilitarians and patients deontologists is wrong or, at best, simplistic. Doctors may be just as -- if not more -- sensitive to duties, rights or virtues as other groups.

Of course, there is variation among each of the groups. Many respondents acknowledged a duty to tell the truth (and thus not to lie) but did not view it as prohibiting non-lying deception. The duty to tell the truth was interpreted literally as a duty not to utter falsehoods. 'Fudging', evading the question or other forms of deception were often recommended:

> If all the signs were pointing towards the new information killing him [Mr Smith] I would attempt to avoid answering the question by explaining there are more pressing things for us to worry about. (doc05)
>
> To be fair, I would probably ask him why he was thinking he might have cancer and, if there was no rational basis (e.g., the heart monitor was going crazy), I would try to explain his symptoms without actually saying that he didn't have cancer. (doc32)
>
> Where Mr Smith is in a blind panic, and we are convinced that Mr Smith is going to have another heart attack, I would probably opt to try not to answer the question (cleverly deflect it in some way!). For some reason, lying still seems a more unacceptable form of deception to me than maybe partially telling the truth. (doc17)

As doc17's comment indicates, while non-lying deception was permitted, lying was often considered out of bounds. Furthermore, as I described in chapter 7 (p.190-191), some respondents did not associate 'fudging', evading the question, or withholding information as 'deception' and thus would answer 'no' to question 14iii).

Another possible reason why many respondents preferred not to deceive Mr Smith is that they assumed that, despite his fear of cancer, he would not respond negatively to the truth, whereas others assumed that disclosing the information might cause a life-threatening heart attack. A few respondents believed that Mr Smith's question suggests that he already suspects cancer and thus that the truth would reduce his anxiety, rather than exacerbate it. As I mentioned in chapter 6 (p.175), this interpersonal variation in assumptions is a methodological weakness of the 'vignette' technique. When I added that Mr Smith's question was accompanied by 'the heart monitor going crazy', thereby highlighting the possibility of another heart attack, respondents appeared more willing to tolerate deception, even lying. The quotes below illustrate this observation:

> I answered 'no' to the question [14iii] because I believe that doctors should be as honest as possible with their patients, particularly if asked a direct question. However, the patient's immediate health should be a bigger priority and the only time a doctor could really be justified in lying would be if the truth is likely to put the patient's life in any sort of immediate danger (e.g., risk of another heart attack). (pat18)

> I think if he [Mr Smith] asks a straight question: "have I got cancer?" then the Dr should give a straight answer unless it would clearly put Mr Smith in danger (e.g., another possibly fatal heart attack). (pat41)

> If absolutely pressed for an answer and his life was at risk then I suppose I would lie to him at that time, until I thought it was safe to tell him the truth. (doc51)

Nonetheless, a few respondents clearly believed that the doctor should tell the truth, whatever the probable consequences. One patient (pat1) focused on the patient's right to know as opposed to the doctor's duty to tell:

> [Tell the truth] because he has the right to know -- even if giving him this info may cause him stress (and as such may be 'medically undesirable'), I do not believe that doctors should be allowed to 'censor' info related to the patient's health.

Four patients (pat27, pat28, pat39, and pat47) stated that doctors should truthfully answer direct questions and that any adverse effects from the answer were attributable to the patient, *not* to the doctor: 'if the patient asks then they [the

patient] have to be responsible for their own reaction to the answer' (pat27). Pat39, justifying the disclosure of Mr Smith's cancer in case 6, affirmed that 'As a broad principle adult patients should be given relevant information about their condition, and be responsible for how they assimilate it'. Another patient comments that doctors should 'answer truthfully if asked' and that 'any consequences are down to the patient' (pat47).

The comments above are interesting in that they focus on the duties and responsibilities of patients. Patients are not passive recipients of treatment, but active interactants in the doctor-patient relationship. One patient (pat9, interview) explicitly stated that patients "have to take some responsibility for their own well-being" and that this entailed asking certain questions. Little attention has been devoted to the duties of patient, but it is very plausible that, like doctors, they *do* have certain duties (including a prima facie duty to 'tell the truth')[280]. Whether these duties include taking responsibility for the impact of answers to one's questions and whether such a duty would absolve a doctor of responsibility for any adverse effects of the disclosure is open to question. Certainly, the answers would depend on a range of personal and contextual factors.

My own view is that doctors should take and accept responsibility for their deliberate *decisions* to disclose or withhold information. Such decisions should surely take into account the likely impact of the particular decision on the well-being of the patient. Rejecting responsibility for the decision risks encouraging doctors to automatically and unreflectively tell the truth in response to any question, however delicate and whatever the *real* reason behind the question (e.g., a desire for reassurance). Personal judgement must always play a role in decisions to disclose or withhold information. Any attempt to eliminate this element is likely to be detrimental.

Truth-telling, deception and the impact on trust

The importance of trust was mentioned by many respondents from each group. Below are some illustrative extracts:

> If I ask, I expect to be told the truth and for the doctor to understand that. I would lose respect and trust with a doctor who knowingly lied when he knows I would prefer the truth. (pat12)
>
> I don't think on a general basis he should go around telling people lies (you'd have no trust in any doctor) but I'm putting it in exceptional cases; it's all right. (pub 9, interview)
>
> As an oncologist, I often have to tell patients bad news. I do this openly and without deception in almost all circumstances, so they know that I am not going to hide things from them, from their own past experience. It is part of the relationship between us, and it is about trust. (onc05)

In chapter 4 (p.104), I pointed out that trust has several possible referents. This research supports that claim. Trust could refer to the doctor acting in the patient's best interests, to the doctor telling the truth or to the doctor not withholding important information. One GP highlights the possible tension between various types of trust.

> You can't function if you don't have that trust relationship and therefore you both have to be honest. Or, at least the doctor has to be honest! If you don't have a relationship of trust then you are nowhere. And is that trust to have your best interests at heart, or is that trust to be honest? I agree, and that's where I think you are stuck with direct questions. (GP01, interview)

Pat12 also acknowledges that trust can have several referents that need not conflict with each other.

> This experience taught me that if I ask a direct question of a doctor I expect his honest answer. Otherwise, I may find out that my doctor lied to me and would no longer trust him. But I feel that if the doctor believes that releasing certain information to a patient without being asked [would be harmful] then the doctor has the right in the patient's best interests to withhold certain information.

The comments above seem to attribute two referents to trust:

1. trust in being told 'true' information (or not being lied to)
2. trust in the doctor acting in the best interests of the patient, without violating 1.

Thus for some respondents it was possible to 'trust' a doctor while accepting that he may withhold information from patients in their best interests. Other

respondents disagreed with the above, however, and believed trust encompassed the doctor volunteering important information:

> Doctors hold a position of trust. As patients we trust them to be honest with us; if they lie or withhold information from us about our own bodies or well-being then they are breaking that bond of trust. That doesn't mean to say that doctors have to be brutal in their honesty either. Patients can for the most part deal with bad news so long as it's done with some semblance of compassion -- the one thing that is truly lacking in the health service today. (pat15)

So pat15 extends the scope of 1 to include 'trust in not withholding important information about the patient's condition'.

Although the first referent -- trust in being told 'true' information -- can permit deception by omission, it still provides patients with an escape route to truth if they should decide to know more. Through direct questioning, patients can extract whatever information they wish to know. If, however, lying were permitted, there would be no way of trusting the doctor's word. The comment below stresses this distinction between lying and withholding information:

> Lying destroys trust. If someone lies, then that's wrong. If they don't tell you, there are other ways of finding out. Asking more questions, looking it up in the library. (pat34)

Although respondents believed deception to be acceptable in isolated cases, some feared that widespread, publicly known deception may have a detrimental effect on public trust in the medical profession. This is reflected in the comment of an 18-year-old interviewee:

> But then...see, that [morally acceptable deception] works in, like, one case but if that were like general practice then who would trust doctors anyway and then it would all fall apart so... (pub2, interview)

On a personal level, lack of trust in the doctor's honesty can cause worry or even paranoia. A patient with multiple sclerosis wrote 'You need to establish trust between doctor and patient. There is nothing worse than feeling paranoid that you are not being told the whole truth.' (pat24)

Another patient wrote of her reaction when she discovered that a diagnosis had been withheld from her:

> Unbelievably, I was deceived when I had ovarian cancer -- dysgerminoma. I was not told or followed up. When I found out several years later I was devastated, angry and hurt at the deceit and the risks that doctors took with my life by concealing the truth and not following me up. How can anyone trust a doctor who lies? (pat6)

The comment above illustrates the powerful knock-on effects that a detected deception, however benignly intended, can have on the current and future doctor-patient relationship. The same patient concluded 'I will never trust a doctor ever again'.

Yet, despite the commonly held association between deception and lack of trust, the fact that a majority of respondents in each group believed that deception by doctors *was* sometimes morally acceptable suggests that, for these respondents, trust in the doctor's honesty can be trumped by other types of trust, such as trust in the doctor acting in the patient's best interests.

The coexistence of trust and benevolent deception

Although nearly all the doctors who took part in the study considered deception to be used either often or occasionally by doctors, most claimed that they deceive only rarely.* Of course, this apparent discrepancy is not illogical -- perhaps the doctors who responded to the questionnaire were particularly honest -- but I suspect there is either an overestimate of the prevalence of deception in medicine or an underestimate of how often doctors see themselves as using deception. Whatever the explanation, the majority of respondents in each group believe doctors deceive either often or occasionally. A paradox emerges here: although deception is seen as prevalent, various surveys apparently indicate that doctors are one of the most trusted professions in British society[281]. This suggests that 'global' trust in doctors and benevolent deception by doctors can coexist, even in the knowledge that this type of deception can, and does, occur.

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* An interesting parallel can be made with Green *et al.*'s study on doctors deceiving other doctors. They found that while 52% of respondents said that they were less likely than their peers to deceive their colleagues, only 3% reported that they probably deceived more[4](p.2320).

In chapter 4 (p.105), I presented Hall *et al.*'s five-part configuration of trust:

1. Fidelity (i.e., considering the patient's best interests)
2. Competence
3. Honesty
4. Confidentiality
5. Global trust (i.e., the overall, irreducible 'feeling' of trust)[157]

The authors point out that honesty can impact on the other dimensions and that 'Paradoxically, therefore, increased honesty might lower trust in other dimensions, which makes the net effect on overall trust uncertain'[157](p.622). Although the restricted sample size and the lack of generalisability prevent me from making statistically valid assertions, the responses in this research coupled with the findings of large surveys on public trust of doctors indicate that perceived deception, even if deemed occasional or frequent, need not undermine the global trust in doctors. Indeed, many patients and members of the public felt great sympathy for doctors who had to make difficult ethical choices about disclosure.

> It [answering the questionnaire] has brought home to me how very many difficult decisions in a short time scale medical people have to face. I am glad I am not in their position. (pat26)

> I don't know, it's very difficult, I wouldn't like to be in their position, I really wouldn't. (pat4, interview)

> Yeah, and you'd have to have a lot of moral fibre sometimes to do the right thing, so poor doctors! (pat8, interview)

This sympathetic acknowledgement of the moral complexity of some truth-telling decisions and the widespread belief in the moral acceptability of benevolent deception might explain why trust in doctors can still exist in the knowledge that they engage in deception.

It must be pointed out, however, that although perceived prevalence of deception may not undermine global trust in doctors generally, the same does not appear to hold if individuals suspect their *own* doctor has deceived them. The table below shows the questionnaire results for the question: 'As a patient, would you find it morally acceptable for your doctor to deceive you if he/she believed such deception was in your best interests?'

	YES	NO	DON'T KNOW
Doctors	33%	49%	18%
Patients	18%	68%	14%
Members of the public	50%	34%	14%

Table 9: survey results for question 'As a patient, would you find it morally acceptable for your doctor to deceive you if he/she believed such deception was in your best interests?'

With the exception of members of the public, a minority of doctors and an even smaller minority of patients would permit their doctor to deceive them. The medical experience seems to accentuate the desire for autonomous decision making. Whatever the precise reasons for the discrepancy between members of the public and the other groups, the results suggest that although public trust can coexist with a perceived prevalence of deception, individuals are more likely to distrust their own doctor if they suspect him of deceiving them.

The dangers of generalisation

People react differently to receiving bad news. Patients may also differ in the amount of information they would like to receive. Salander *et al.* showed that many patients diagnosed with malignant brain tumours decide not to ask 'the vital questions' about prognosis[274](p.990). These interpersonal variations have important implications for the moral acceptability of deception in medicine. Respondents from each group stressed that the decision to disclose and how much to disclose depended, at least in part, on the patients themselves. Pub6a (interview), for example, said:

> I think he [the doctor] would have to take into account the individuals and what you know. If you're somebody's GP you'll hopefully know a little bit more about them and their circumstances. And how they might react to things.

The dangers of assuming that all patients desire the 'whole' truth are highlighted by pub12, who writes: 'I think that doctors should never assume we all want the facts with a "warts and all" delivery'. In the words of one interviewee, an 85-year-old member of the public, telling patients the harsh truth may "knock some people sideways" (pub5, interview). Another 'public' interviewee describes that a friend who was not told about a diagnosis of multiple sclerosis for 10 years was 'very happy' not to have been told (pub6, interview). Pat3 described herself in an

interview as "the sort of a person who won't want to know very much when you're actually going through it but when you've actually been through it I will want to know everything about everything." The variable suitability of deception is in line with the views of derm1, who commented: 'Different patients with different diseases/situations require different approaches. My view with regards to one patient will differ from that with another.'

This variability in personal preferences is evident from the comments of patients. Pat35, who suffers from HIV, wrote that he would not object to being deceived about certain aspects of the disease:

> If it was a deception that stopped me making a choice, I'd be furious. However, if it was keeping me in the dark on an issue of mortality, I'd prefer not to know frankly, so deceive away!

Similarly, pat22 (multiple sclerosis) wrote: 'At the end of the day, I do not want to be told I'm going to die or I would lose all hope and [it would] make my last days worse.'

The main danger of a hard rule prohibiting deception and enforcing truth-telling is that it runs the risk of setting the doctor on auto-pilot, preventing him from assessing the situation in context. This may avoid uncertainties on the part of the doctor, but could also have adverse consequences for the patient. In an opportunistic interview, an SHO said:

> Always telling the truth is the easy option for the doctor -- it's categorical. It's easy. But it's not always what's best for the patient. A year or two ago, I used to always tell the truth, but now I've changed and it makes it much harder for me.

Another risk is that doctors may simply dupe patients through clever uses of true information. One GP gives the example of using percentages to communicate likely outcomes to patients who may not really understand what these figures represent:

> I would explain using diagrams as there is strong evidence that many patients do not understand percentages. If I am using percentages, I would ease my conscience by telling the truth but may not have shared any understanding. (GP21)

As I mentioned in chapter 2 (p.17), truth-telling and deception are not mutually exclusive.

One palliative care doctor commented:

> "One size fits all" answers are [...] inappropriate. To have a stock response for all patients is in my view unethical -- you may as well give out a leaflet or leave it to a computer program. Part of a doctor's job is to tailor the treatment to the patient's needs and desires, and information giving should be regarded in the light of the patient's right to information, not a duty to receive it. (doc24)

A good doctor, then, has to ascertain how much a particular patient wants to know and not impose unwanted information. Yet even members of the public acknowledge that uncovering exactly what the patient requires could be very difficult, if not impossible. Pub10, for example, commented:

> I think it's perhaps impossibly difficult for a doctor to know whether to deceive or not to deceive: it depends on a host of factors about the patient's life that it would be hard for the doctor to be fully informed about.

The doctor as explorer

In light of the diversity of patients' views and beliefs, part of the doctor's role is to unearth what individual patients want to know and, more controversially, how much they should know. One GP said in an interview that she is "guided by what the patient tells me their need for information is and I think that's my primary aim -- to find out what they want to know". So how do doctors decide whether -- and how much -- to reveal to a patient? An oncologist (onc2) wrote:

> When I see a new patient with cancer I try to ascertain their requirement for information and likely coping strategies. The amount of information given and the way it is imparted is then adjusted appropriately (as best one can). Withholding information not asked for is a common deception in oncology.

GP01 (interview), however, does not consider withholding information or using vague or euphemistic language to be deception if used with the intention to explore the patient's wishes and as part of an ongoing relationship. "I put a woolly question or a woolly statement in their court and wait to see if they'll elaborate and I don't think that's unethical". Burton and Parker, in their study on

surgeons' attitudes towards psychological aspects of cancer surgery, showed that 49% of their sample of 51 surgeons endorsed the same exploratory technique: 'using the word "growth" and waiting for the patient to ask for further details'[187](p.50).

One oncologist (onc01, interview) also asked the patient about his understanding of the situation to gauge comprehension of a) the situation and b) the medical terminology. She described herself as 'very sensitive to cues'. When asked to elaborate, she distinguished between *explicit* cues, such as asking outright to know or not know some information and *implicit* cues, such as failing to pursue a topic of conversation. Below is a description of how she would disclose information to a terminally ill cancer patient. It clearly explains the incremental process of exploration and the doctor's reliance on the patient's reaction to information 'hanging in the air'.

> [I] give a bit of information like, you know, you could have this treatment and, you know, it might make the cancer stay away forever or the cancer may at some stage come back and that then leads to the next piece of information sort of hanging in the air and then if they want to know they'll say, if it comes back, what does that mean? And then you'll say, well then I'm afraid it's not possible to cure it because it might have spread to other parts of the body. Then again, if they want to know, they'll ask more, like well, you know, and then the final question, which takes a lot of courage to ask, is well, you know, how long do you think I've got? And I'll only tell them that, well my guesstimate of it if they ask that question. I won't come out with all that stuff if they haven't specifically asked. So I try to build up a relationship with people and allow them to tell me what information they want to know.

Another oncologist, who deals specifically with aggressive tumours with poor prognoses, also provides an example of this inquisitive 'technique':

> One technique would be to explain the extent of the metastatic disease, to go through an investigation like a CT scan and perhaps even to use a phrase like say, 'well you know obviously this is serious because it involves the liver', and then immediately to follow that up with, 'are there any questions you want to ask?' because you know at that point, you know [...] 'Serious? What does it mean, what does that mean for my survival?' is almost certainly going to be in their head and you're then cuing them in, you know, that's a pretty direct way, I mean that's a fairly brutally direct way of saying, 'do you want to know?' you know, 'is now the time to talk

> about time and time scales?' and that often elicits a request for prognostic information. (onc02, interview)

In their role as explorers, doctors need to be as attentive to what is said as to what is not said. The clues may be subtle, forming little more than an 'impression' in the doctor: "just the things, the little things they say, you just get the impression of how much they want to know." (onc01, interview). For others, it is a feeling or intuition that is hard to articulate:

> It [telling the truth] doesn't feel like the right thing to do and you just have to do...I guess you feel, you know, you get a sense of what feels comfortable, don't you, in a conversation. (haematologist1, interview)

> I think you have some antennae and some clinical acumen and you don't always get it right [...] I find it very difficult to express to you how you sense that [how much to tell], but you do. (gastroenterologist1, interview)

> I mean you tend to sort of develop your own internal model for how you handle these things and the model isn't necessarily well worked out at the level of consciousness. (neuro2, interview)

Of course, withholding information without consent is not *necessarily* deceptive. Instead of violating the patient's autonomy, it may be respecting it by allowing him not to know what he does not wish to know. This idea was expressed by several respondents and interviewees. Pub12, for example, writes 'If I don't want to hear it, then I won't ask. If I do I will. I hope I can communicate this fact to him'.

Some doctors hold the belief that patients who do not want to know should not be forcibly informed. Disclosing a grim prognosis should not be done without the patient's permission, which is often obtained through the use of open-ended questions. However, there may be limits to the constraint imposed by the patient's desire not to know.

> I only like to give information if the patient has indicated to me that they're ready to know that. That's exactly what I said. If they've given me strong cues that they're not ready to know that [information], if they don't want to know that, then I'll withhold it, but I will try, because of what you said that there are practical implications of patients with cancer that, you know, and you know... [pause] or it's where you know they're going to need to put their affairs in order. (onc01, interview)

Later in the interview, onc01 said:

> *Onc01*: I think patients with cancer should have the information that they've got cancer and they should know, you know, the treatment plan and what's going to happen if it works or doesn't work and the likely prognosis.
> *Interviewer*: But not the prognosis?
> *Onc01*: Well, the prognosis if they ask.

For onc01, it seems that the constraint holds until the practical implications of not knowing are sufficiently important to warrant disclosure. But then why should prognosis only be disclosed if asked? The reason appears to be that there is a relationship between asking about prognosis and psychological acceptance of the disease. This might be combined with a certain reluctance to commit oneself to a specific figure and/or a fear of negatively affecting the patient's state of mind.

The difficulty lies in interpreting the patient's silence if they do not 'pick it up' (in the words of GP01). Is the silence motivated by a desire not to know, as in the case of pub12 above, by sheer ignorance or just a natural reticence of personality? Onc01 (interview) described how she deals with this eventuality:

> Ah, I don't think they don't ask through ignorance, I think if they don't ask they don't want to know. No perhaps you're right, there may be some cases where it doesn't occur to them how ill they are, yeah. And then if I get that sense from people and I do get that sense sometimes, that they just really haven't got a clue, although I've given them some information, which some people would pick up on and say, "Well what do you mean by that doctor? How long have I got?" but they don't do it, they just think it's going to be fine, they're going to have some more treatment and they'll go back to being fine. Then I will *try to introduce* the subject if I can see that things are starting to go downhill, I'll *try to say*, you know, "I'm afraid this doesn't look like it's going too well and if the next treatment doesn't show any benefit, then I'm afraid we'll have to stop" and then they'll usually say, "Well what happens after that?" if they don't, then I'll, *I might say*, "Well then I think we'll be getting to a difficult stage where we don't have any active treatments to stop the cancer growing". (emphasis added)

The tentative language suggests that guiding the disbelieving patient towards asking the 'right' questions is a delicate and uncertain process.

The oncologist above refers specifically to patients ignoring the gravity of their condition. The present research highlighted a number of other reasons why patients may not respond to doctors' cues. One cancer patient questioned the

assumption that a failure to ask questions indicates a desire not to know: 'doctors should not always wait for the patient to ask questions -- in many cases patients do not know what to ask, especially if the medical problem is new and they have no experience of it.'(pat29). In one cardiac patient focus group, as well as in other patient interviews, respondents provided several reasons for a failure to ask questions:

1. The patient does not know which questions to ask, either because of medical 'ignorance' or differences in cultural background
2. The patient feels that his ignorance of medical terminology prevents him from asking questions
3. The patient is too shocked by prior disclosures (e.g., disclosure of cancer diagnosis and need for surgery) or too unwell to ask questions
4. The patient feels asking questions would be questioning an authority figure and thus inappropriate
5. The patient does not feel comfortable with the doctor
6. The patient 'puts on a front' that disguises his true worries and concerns

These reasons cast doubt on the validity of the 'subtle' approach to exploring patients' informational needs. The leading questions of doctors may not be picked up by patients who *do* want to know the facts. Illness renders some people vulnerable and the appeal to patient autonomy, oft-heard in the bioethical debate, tends to assume that all 'competent' patients have as much autonomy as non-patients. This may be true in some cases, but not in others. One cardiac patient commented "when you are about to have a bypass operation, you probably don't know what time of the day it is", while another said that once a bad diagnosis is made "you may be in such shell-shock [...] that you won't be able to think of any questions" (cardiac patient focus group). This supports the view of Onora O'Neill, who claims that

> [...] because of the vulnerability and weakness of patients, even informed consent procedures (let alone more robust conceptions of individual autonomy) may be less apposite and less realistic in medical practice than in almost any other area of life[90](p.40).

The dichotomous division of competence into competent/incompetent does not capture the graduated or selective nature of competence. The 'subtle' approach to disclosure adopted by some doctors may be fundamentally flawed. It is worth noting that one neurologist (neurologist1, interview), acknowledging the difficulties some patients have in assimilating all the information, tapes all his consultations and gives patients the tape so that they can listen to it at home.

However delicate the exploration process, it appears that oncologists consider it a duty to manage their patients' expectations, to guide them from uncertainty or ignorance of their condition to knowledge and greater certainty. To enhance patients' autonomy -- and to empower their patients -- doctors may have a duty to ensure that patients' expectations are based on realistic medical facts.

> I think that the degree to which one doesn't push things varies from oncologist to oncologist, I don't think there are many out there now who would allow clearly incorrect perceptions to persist. I think that, you know, if you've got somebody who's... whom you expect to survive a few months and they're planning for an event three or four years hence, you have a duty, I mean most oncologists recognise you have a duty to correct that in that, you know, it's an important part of the job -- managing patients' expectations so that they can plan the time they've got left appropriately. (onc02, interview)

Although the duty has ethical foundations, it also serves a practical purpose, which is to avoid the threat of litigation. Onc02 (interview) said "we're often taught it's not bad outcomes that make people complain about their treatment, it's poorly managed expectations". This is an important consideration for doctors at a time when patients can readily voice their discontent with potentially disastrous consequences for the healthcare staff involved.

Pub3 twice refers to the metaphor of the 'mine field' to refer to the difficulty of a doctor's decision to disclose. The phrase suggests that it is impossible for doctors to know for certain what the patient requires. As one patient said (pat8, interview), patients "might look a state but [...] could cope well with what you tell them". This uncertainty introduces an element of guesswork in their decisions. One consultant anaesthetist, doc7, found that the questionnaire has made him more aware of the uncertainty involved in making decisions about disclosure. Asked if the questionnaire has affected his views on the issue of truth-telling, he replied: "[I] realise I have no absolute knowledge of what patients would want. I can only guess and make assumptions." One oncologist admitted that doctors sometimes misjudge the informational preferences or desires of their patients:

> *Interviewer*: When you're wrong, you mean, either you've told them too much or not enough or...?
> *Oncologist*: We've completely misjudged the situation as to whether they wanted the information or didn't want the information and just

> occasionally lines of communication completely break down with patients because you've blown it. You've either told them too much -- you've told them things that they didn't want to know -- or you haven't told them things that they did want to know. (onc05, interview)

It is perhaps because of this uncertainty that all the groups attribute special status to direct questions. Many of the doctors who would be willing to deceptively withhold important information from a patient would not be prepared to lie when asked a direct question. A direct question seemingly dispels any uncertainty and indicates that the patient really wants to be told the truth. One oncologist said "if they [patients] ask a direct question they're saying that they can cope with the answer" (onc05, interview). Pub44 echoed this view: 'If somebody asks you directly, then you should tell them. Otherwise, people when they're ill and don't want to know something, they tend not to ask.'

A dermatologist (derm2) went a little further than Pub44 by incorporating the adverb 'repeatedly': 'The patient wishes to know and asked repeatedly and should be told'. The inclusion of the adverb emphasizes the need for sustained asking to ensure that this is what the patient truly wants. The same caution is displayed by an oncologist (onc02), who wrote: 'When patients ask direct questions they *usually* expect truthful answers.'(emphasis added), suggesting that some patients ask questions without wanting a truthful answer. They may be seeking reassurance rather than factual information. A cancer patient expressed this possibility:

> Well I think the person will have said "have I got cancer?" because, okay some people may be asking that because they want somebody to say no, you know, and they don't want them to say yes but on the other hand if somebody's asked that it's very difficult to distinguish who wants to, to really know and who doesn't want to know and if you, if you say no and they, they have got cancer then that doctor relationship is going to go out of the window (pat3, interview)

The danger of taking a patient's refusal of unpleasant information at face value is most clearly expressed by one neurologist who specialised in motor neurone disease:

> *Interviewer*: But do you have patients who just say, 'look I don't want to know the gruesome details'.
> *Neurologist*: Yes.

> *Interviewer*: And so what do you do in those cases?
> *Neurologist*: I don't do one thing, what I do is I try and understand the semiology of that statement okay, and it may be that 'I do really, but I'm terribly frightened'. Or it might be, 'what I want you to do is to tell my husband or wife and they'll talk to me later, but I do want someone to know'. Or it might be anger, you know all sorts of things, but if I take the view that it's a simple request to be fobbed off, I think that's actually wrong in my experience.

This extract supports the distinction made by the philosopher David Thomasma between factual truth, which reflects an objective reality, and *interpretative* truth, where the 'responder looks for the reasons behind the question, and instead of responding factually to the question responds to those presumed or interpreted reasons'[148](p.377). Distinguishing between a 'genuine' question and a call for comfort disguised as a question requires the doctor to be aware of the patient's personality and mind-set.

The patient as explorer

Just as doctors attempt to assess how much the patient before them wants to know, patients may also try to extract information from the doctor. They too can be regarded as 'explorers' in search for a greater understanding of what is happening to them and, often, what will happen. It is perhaps for this reason that lies are considered by many to be morally worse than other forms of deception. Lying may be a greater hindrance to the explorative task of patients than evasions or omissions:

> Well it's reading between the lines [...] because if somebody has said "Have I got cancer?" and the doctor says "No" that is very clear cut, whereas if somebody says "Well you've got a growth" etc, etc. Now if somebody's on the ball and reads between the lines they may turn that situation into saying "Well look doctor, is this cancer?". (pat3, interview)

Lying does not allow patients to 'read between the lines', whereas other forms of deception *do* allow shrewd patients to get at the truth. In this way, lying is more unfair than non-lying deception, as it completely stifles the patient's possibility to discover what he is looking for. The data above lends support to the idea put

forward by Piers Benn that 'lies tend to place more demands on people's self-protective capacities than do non-lying deceptions'[29](p.134).

During a consultation, both parties are engaging in subtle detective work, trying to gather information through direct and indirect questioning. The doctor is trying to discover the extent to which he should disclose information, while the patient is usually trying to unearth details of his condition. This mutual probing is rendered more delicate when both parties do not know each other very well, as in some hospital encounters, and thus cannot rely on prior knowledge of the person's character and preferences. This is one reason why a questionnaire that would allow both parties to share their views on the issue of truth-telling may be desirable, as it would give explicit, though not necessarily fixed, indications of what each party is looking for. A more thorough discussion of this idea appears in chapter 10 (p.256).

Two doctors mentioned a strategy that patients use to unearth information from the doctor. Just as doctors may make a comment with the intention to interpret the reply (or non-reply) as an indication of how much the patient wants to know, patients may do the same to assess the doctor's views on some aspect of their condition. For example, instead of asking explicitly how long he has to live, a cancer patient may mention his intent to attend his daughter's wedding in the future and interpret the doctor's reaction.

> You [the doctor] might want to know whether it [mentioning the wedding] was a slightly indirect way of actually asking you 'Will I die in the next six months?' in which case that has to be handled on its grounds. (neuro2, interview)

> [..] a patient has often set that [the assertion] up deliberately as a way of finding out information. You know, they don't want to ask, 'how long have I got?' so they'll say, 'right, okay, daughter's wedding in four years time, mention that to the doc, doc says nothing, he obviously thinks that's not a problem'. (onc02, interview)

Whatever the doctor's response, even if it is only silence, the patient will derive information from it. McIntosh, in his survey on patients with diagnosed but undisclosed malignant cancers, showed that patients 'worked out' their diagnosis by what was *not* mentioned:

> They [patients] assumed that an unthreatening diagnosis would be disclosed to them and the absence of such a disclosure was taken to indicate that their condition must be something more sinister[275](p.301).

McIntosh's study was conducted in Scotland, in the mid 1970s, and many patients did not expect doctors to disclose a diagnosis of cancer. Today, the silence would no doubt be interpreted very differently. The 'wedding' scenario is a good example of how silence can be deceptive in a context where the speaker expects the listener to correct any errors. It is worth noting that some of the doctors interviewed differed in their views of how to respond to such an indirect question. While some would correct the false belief, others would not. One gastroenterologist said:

Gastro1: I think if they said straight out, 'my daughter's getting married next year, what are the chances of me being there?' I would say, 'we're going to do all we can for you and we'll do our best but we can't promise'.
Interviewer: But if they didn't ask, if it...
Gastro1: If they didn't ask I wouldn't induce further anxiety.

This points to the unreliability, from the patient's perspective, of indirect questioning. Just as patients may fail to respond to exploratory cues, so may doctors.

In the previous section ('The doctor as explorer'), I listed several reasons why some patients felt unable to ask questions in response to the subtle cues of doctors. In light of these reasons, many patients find out about their condition themselves:

> *Pat10*: I found out far more about my disease from my own research than from the doctor.
> *Interviewer*: And is that because you were reluctant to ask questions or because you found the doctor didn't actually tell you much or didn't know much about it?
> *Pat10*: (sigh) A bit of both. It's not that they don't know much; I think they don't know how to explain it and there's far more to explain that can be done in (inaudible) 10 minute consultation.

This supports the findings of Kirk *et al.*, who found that cancer patients receiving palliative care obtained information about their illness from secondary sources (family, friends, Internet, literature, support groups) as well as from the healthcare team[279]. Using secondary sources allows patients to gather details about their

condition in their own time, in a less threatening environment, free from the constraints of a brief and sometimes intimidating encounter. The patient's exploration thus occurs both within and outside the consultation. It is worth noting that doctors often appear to be aware of this private investigation outside the consultation. This may provide an additional incentive to disclose bad news. Doctors may well prefer that patients discovered adverse information from them in a supportive context than from a written source that may be unreliable and unable to provide support.

Finally, one neurosurgeon suggested that some cancer patients who have undergone an operation lie to the oncologist about the information they were given in order to get a second opinion:

> [...] so one gambit I think some patients play, quite an interesting constructive thing, I think very reasonable, I'm not blaming the patient because if it was me I'd do the same thing, I would say, you know, I want to start with a blank sheet, "No the surgeon didn't tell me anything", you know, come on and tell me it again. (neurosurgeon01, interview)

To obtain more data on this strategy, I contacted several oncologists for their opinions on the neurosurgeon's comment.* Extracts of their responses are reproduced below:

> They [patients] will often claim to be in the dark when in fact they have quite a lot of information. It seems a legitimate mechanism that patients use to glean more information. (onc05, interview)
>
> It's quite possible that [...] when asked "what have you been told?" [patients] will reply in a way that deliberately doesn't say exactly what they have been told. [...] I think I'd agree with your neurosurgeon that it's an interesting approach to getting an independent opinion. (onc04)
>
> I have found exactly the same thing -- patients have often said that they were told nothing. Occasionally I suspect that they were told in a way that they didn't understand (e.g., use of words like lesion, carcinoma etc). However often they've seen a surgeon whom I know wouldn't have left them without info, and I completely agree with your interpretation. Sometimes a patient will say "I was told nothing", then I'll embark on what I see as the situation, and they'll come back with "Yes that's pretty much what Mr So-and-so said". (onc01, interview)

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* Strauss and Corbin call this strategy 'discriminate sampling', which involves choosing sources that are likely to help 'saturate' a particular category[19](p.211).

Two cancer patients corroborated the comments above in a personal e-mail:

> I must admit to not always telling them [doctors] everything I have been told to see if the opinions vary. (pat25)

> I know from women in other parts of the world that doctors have differing opinions on how to treat ovarian cancer. If I had gone for the second opinion, I would have behaved exactly the same as the patients you describe, i.e. I wouldn't have told the second doctor what the first doctor had said in case it coloured his opinion. (pat31)

This strategy is not limited to cancer patients. A Senior House Officer (SHO02, interview) working in Accident & Emergency recounted how a patient asked her what diverticulitis was, despite having suffered from the condition for over a year, consulted her GP and obtained regular treatment for it, and presented herself as 'having diverticulitis'. The SHO commented:

> She [the patient] wanted some confirmation. She'd been seeing her GP regularly for it. I think she probably wanted an independent opinion again [...] She might also be asking to check I know what I'm talking about. I mean, I look about 12 years old!

Pretending not to know is another explorative strategy used by patients to unearth the 'true' state of affairs by gaining a second opinion and, perhaps in some cases, to assess the competence of an unfamiliar doctor.

Changing views on the moral acceptability of deception

Some respondents who initially had hard-line views on deception relaxed their absolutist position by the end of the questionnaire, anchoring the morality of deception on a range of context-dependent factors. The comment below is a good example of this realisation. The respondent also alludes to the possibility of certain situations being genuine moral dilemmas.

> I would have thought that honesty was always the best policy. However, I think that a doctor needs wisdom to know how to be honest in a tactful way. [...] Case 4 makes me think that honesty with the patient isn't always a good thing, as it may be kinder to make the patient comfortable in their final few minutes, rather than panic and distress them. Having said that, whilst I personally would prefer not to be told of a fatal blunder in the final minutes of my life, some people might prefer to be told. Perhaps

> there isn't really a straightforward right or wrong answer to that question? (pub36)

Pub56 writes that the questionnaire has 'made it clear to me that there are no absolutes on truth-telling'. One GP (GP24) shifted his position from one scenario to the next: in case 3 (trivial mistake), he states that he would alert the patient of his mistake and adds as a comment: 'It is always best in my experience to come clean'. In case 4 (lethal mistake), however, he opts not to tell the patient of his fatal mistake. Similarly, GP25 writes in case 1 (non-paternity) that the doctor should disclose the information, justifying the decision with the words 'Honesty at all times!'. Yet he opts not to tell a patient of a fatal mistake in case 4 and, at the end of the questionnaire, he answers 'yes' to the question 'Do you believe it is ever acceptable for doctors to deceive their patients?'.

Respondents in other groups also modified their positions during the interview or questionnaire, some in light of apparent contradictions in their responses. For example, pub5 (interview) said that withholding the information about non-paternity to Susan and her father *was* a form of deception but that it was nonetheless justified:

> A: Well, as I said before, I think the top and bottom of it is if you can save a bloke's life all the rest of it doesn't come into it, to me.

Later, however, when discussing the case of Mr Smith, he appears to contradict himself:

> A: That's right. Certainly. I don't know. I think, taking everything into ... I think the truth is always best. Because if you're going to go, you're going to go. Whatever age, whatever anybody says. If the writing's on the wall and you're number's come up, you're away aren't you? So I don't know whether it matters deceiving people or not. If it's done with good intentions all well and good personally.

When the contradiction is pointed out, the interviewee acknowledges -- and attempts to resolve -- the problem:

> A: Well I know, I know I did, but you see you've got me over a barrel, I mean in that case [Susan and non-paternity] truth doesn't come into it because if he upsets her so much that she might refuse to give him the

> kidney she might be condemning that poor chap to death mightn't she? So, it's difficult. You could talk like this for hours.

One patient with endometriosis described how the interview had altered her views on truth-telling:

> To a certain extent [the interview has changed her mind] because I would have said in the first place 'yeah, deception is always wrong', but you've pointed out situations where it might be in the patient's best interests but, you know, I'm still a bit bothered by it. (pat10, interview).

The patient went on to reflect how, as an editor, she regularly deceives authors whose applications have been rejected by affirming that the subject matter is untimely or using expressions such as 'we very much enjoyed reading your book'. Another patient (thy11) also backtracked on her earlier belief that deception was never acceptable, adding 'I have only this week had the tooth fairy visit my youngest son'. The conclusion to be drawn from such frequent changes of opinion is that there may be a difference between people's initial reaction to the issue and their more deliberated position.

Conclusion

To return to the initial question about the moral acceptability of doctors' benignly intended deception, the list below provides a brief summary of the circumstances in which such deception may be morally permissible:

- Telling the truth is likely to cause serious physical harm that may be avoidable through deception (e.g., withholding a diagnosis of cancer from an MI-prone patient)
- Telling the truth is likely to trigger preventable emotional reactions that will adversely impact on the patient's health and recovery
- Telling the truth may lead to a loss of hope (which, in turn, may lead to serious physical or psychological harm)
- The deception is temporary and the truth will be disclosed at a more appropriate time
- The patient is reliably believed not to want a 'full' disclosure (e.g., the patient has asked in advance not to be told a diagnosis)
- The patient has not directly asked for the information, and telling the truth might result in serious physical or psychological harm.

- The patient is not sufficiently competent to make an informed decision (e.g., a delusional, alcoholic patient) and deception is considered to be in the patient's best interests.

The widely perceived dependence of the morality of deception on context, the patient's personality, and his state of mind at the time makes it difficult to provide a rich account of when deception is deemed morally acceptable. The rather bare character of the list has the benefit of broadly capturing the conditions under which respondents believed deception might be morally permissible.

In chapter 4 (p.96), I referred to Søren Holm's research on the ethical reasoning of Danish doctors and nurses. He tentatively suggested that his respondents viewed the right to be told the truth as absolute, unlike the other prima facie rights and duties that he identified.

> The duties and rights identified here are not seen as absolute; all of them (*with the possible exception of the right to be told the truth*) can be superseded by other considerations[17](p.123-124) (emphasis added).

My research indicates that the right to be told the truth is not perceived as absolute by many of the doctors, patients or members of the public who took part in my study. Certainly few believe that patients have a right to know the 'whole' truth about their condition. This would require them to become experts in their disease! As mentioned in earlier chapters, one needs to establish what counts as 'truth' in the 'right to be told the truth' or the 'duty to tell the truth'. This is not always uncontentious, as the divided responses in case 1 (non-paternity) demonstrate. Even if 'truth' is understood as 'relevant information that the patient would reasonably expect to be disclosed' the majority of respondents believed that there are times when the doctor is not obliged to reveal this information, such as when the patient is likely to be seriously harmed by the disclosure with minimal medical or psychological benefit. More plausible, however, is the claim that many doctors consider the duty not to lie to patients as absolute, although the data are not sufficiently conclusive to affirm this claim with any great confidence.

Although the findings in my research are at odds with Holm's tentative suggestion that the right to be told the truth is considered absolute by healthcare professionals, they coincide with his conclusion that the ethical reasoning of healthcare staff is

pluralist and typically consists of a combination of deontological, consequentialist and virtue theoretic elements whose relative moral weights are dependent on context[17](p.166). The next chapter examines in more detail the circumstances in which the 'duty not to deceive' can be overridden.

CHAPTER 9

The Functions of Deception

The popularity of deception in everyday life reflects the many functions of deception. In the context of medicine, doctors generally use deception as a form of information-control allowing them to influence patients' thoughts and actions. This section summarizes the main reasons why doctors might deceive their patients, as judged by the comments of the stakeholders. As I will discuss later, the findings suggest that benignly intended deception may be used not only to benefit others but also to benefit the deceiver, for example as a defensive tool to protect doctors from criticism, stress and the unpleasantness of disclosing undiluted bad news. Benevolent deception may not be entirely other-regarding, but self-regarding too.

Humane deception

Deception can be used not just to avoid the truth but also to disguise it. This idea is related to the discussion in chapter 4 of disclosure as 'translation' (p.81). A doctor's translation of a diagnosis or prognosis can be so different from the 'original' that it becomes deceptive. But what is the original? The relevant, factual information pertaining to the medical condition? Does that include the prognosis? Does the doctor's opinion on the situation also form part of the 'original'? As established earlier, respondents vary in their interpretation of what constitutes the original and how it should be translated. Although nearly all agreed that different individuals require different translations, they also believed that accuracy of disclosure should be coupled with sympathy and compassion. The idea underpinning the category 'humane deception' is that accuracy should be constrained by compassion when the former is likely to adversely affect the well-being, physical or emotional, of the patient. The deliberate inaccuracies of the translation, even if misleading, are thus justified on grounds of humanity.

The idea of 'cushioning' a grim truth was often expressed by respondents. A 75-year-old interviewee (pub9) was asked whether she would always tell patients the truth if in a doctor's position. She replied:

Pub9: No, I would cover it up; wrap it up in some other way. I wouldn't say, "Look, you've had it."
Interviewer: And sometimes you might lie, sometimes?
Pub9: Yes, I would lie; I would cover the whole thing up, wrap it up.

In the same interview, pub9 says that she is in favour of "wrapping it [the harsh truth of an illness] all up like a Christmas present, you know; not really letting them see the heart of the matter". One cancer patient stated that doctors occasionally have to 'develop some cotton wool to go around words to explain things'. (pat1)

The idea of wrapping up or cushioning the nasty truth, making the outside look rosier or less threatening than the reality within, is central to the discussion on the functions of deception. The cushioning can occur at various linguistic levels, from the overall 'feel' of the disclosure to the individual word. To illustrate the latter, one neurologist said that he would tell a patient with rapidly progressing motor neurone disease that the "illness will be shorter". When questioned about the significance of his choice of the word 'illness' (instead of 'life'), he did not appear to be aware of the peculiarity of the phrasing.

Related to the above is the idea of deceiving to avoid 'rocking the boat'. This is a phrase that was heard several times in interviews. The reasoning is: if withholding an adverse prognosis, even in the knowledge that the patient is overestimating his remaining time, is unlikely to affect a person's currently happy life for a while, then why 'rock the boat' prematurely? This idea is clearly expressed in the comments of one oncologist:

> Sometimes if, say, a tumour has come back and it's going to kill them, but it might not kill them for nine months or two or three years, I certainly would feel it would be reasonable not to tell them that they've got a very limited life straight away, because they might think that they've got five or ten years and the whole point of treating people is to help them to enjoy their life and if, for a short period of time, while they're feeling relatively well and they're up and about and they're at work and all that kind of thing, if they think that maybe the prognosis is better than it is, I think that's fine.

> It's once they start to get ill and they start to need extra support and pain relief and so on and their families really need to know, then I think I would certainly make every effort to make sure that the patient -- and if not the patient certainly the family -- was fully informed. (oncologist 1, interview)

Many respondents justified withholding information from Mr Smith using language containing violent imagery:

> "You don't knock a man when he's down, do you"? (pub9)

> "It's an impossible question. I mean it might knock the fella sideways mighten it?". (pub5)

> "It's like, if somebody's already on the ground you don't kick him while he's down, you sort of let him get up on his feet first and then certainly tell him." (pat1)

Pub3 (interview) also uses a metaphor to convey the danger of truth-telling in the case of Mr Smith:

Pub3: [don't tell Mr Smith] Because you're going to push him over the edge otherwise.
Interviewer: Yeah.
Pub3: And there's no need to be *that* brutal.

One oncologist (onc01, interview) used the phrase "to wallop them over the head with it" and another (onc02, interview) "to really hammer it home" to describe disclosing a grim prognosis. One cancer patient (pat29) explicitly stated that doctors should avoid 'bombshells'.

These expressions of violence suggest in colourful terms the potentially devastating impact of disclosure and the vulnerability of the patient. Telling the harsh truth to a sick patient is akin to a fierce punch delivered to a helpless victim. A similar finding was made by Gordon and Daugherty in their study on oncologists' attitudes about disclosing a prognosis of cancer in the United States [143]. They found that many oncologists expressed their reluctance to disclose an adverse diagnosis of cancer by using violent metaphors such as "I don't want to hit someone in the face with it" or "It's probably not the best strategy to just hammer them with it"[143](p.155). The present study shows that the use of these metaphors is not limited to doctors. They are also used by other groups to convey the potentially undesirable consequences of truth-telling.

Hope-maintaining or hope-enhancing deception

In chapter 5, I examined how, throughout the history of medicine, maintaining the patient's hope has been a popular argument for non-disclosure, encapsulated by the Hippocratic dictum *primum non nocere*. The present research shows that what Miyaji termed the 'preserve hope principle' is commonly invoked and supported by all groups[15]. In the scenario of the 26-year-old woman dying of cancer who asks the doctor whether she should write stories for her children, the overwhelming majority of respondents chose the option combining a subtle indication that she may not have long with a healthy dose of hope ('tell her that you don't know for sure but that it would be sensible to write the stories because it's a good idea to hope for the best but prepare for the worst'). The popularity of this option is an indication of the perceived importance of hope. One dermatologist said:

> I don't want to destroy hope. The language may be used not to destroy hope. It should be titrated to the particular patient. I might get it wrong, but...I think optimism is a requirement in life. [...] I think that realism is sometimes depressing and that optimism is needed to keep everything going. (derm1)

One oncologist stressed that he "focused on the positive aspects", highlighting the possibility of the patient being one of the 'lucky few', even though the doctor may think this highly unlikely. He provides an example of what he would tell a cancer patient with a grim prognosis:

> "It's unlikely you'll survive three years but there is a recognised proportion of patients that do and you know, so one of the reasons we give chemotherapy is because we don't know who that 1% is going to be and it might be you." You know, I may feel privately it's not, but I don't know and therefore I guess it doesn't count as deception. (onc02, interview)

A neurosurgeon demonstrated the same technique:

> [...] so I will say to them that "I'm afraid the majority of people will have recurrence and will die within a two year time frame but there are some patients in whom that doesn't happen and I don't know that you're not going to be one of those patients so we must go forward in a positive way". (neurosurgeon02, interview)

Another oncologist also talked of selectively emphasising certain aspects of the prognosis: "I'll be optimistic by trying to emphasise those better quality of life aspects rather than the worst quality of life aspects." (onc05, interview)

Similarly, a neurologist (neuro2, interview) said the wide spectrum of possible prognoses in multiple sclerosis allows him to give an optimistic estimate, even though he has no real idea of what will happen, while a gastroenterologist talked of "just keeping the window open" when the chances of recovery are virtually nonexistent (gastro1, interview). He added: "I think there should always be the statement that we can never be sure, because we can't." A haematologist gave the example of a patient who has accepted a bone marrow transplant with a 20% chance of death.

> [...] once they've made the decision to have the transplant and go with it I will then tend to try to be positive and say look don't worry it's going to be fine and make those sort of noises so I suppose then, am I not maybe, am I telling the truth? When I say it's going to be fine I don't always say "but there's a 20% chance I might be wrong!". (haem1, interview)

Many respondents agreed that there are times when telling the truth can have negative consequences, not only for the physical health of patients (as in the case of Mr Smith) but also their psychological well-being. Some patients, for example, may be emotionally too fragile or labile to 'handle' the truth:

> By doing reading about the type of cancer I had, I know that questions I asked were not answered truthfully. However, that is the benefit of hindsight and probably I was not emotionally strong enough to cope with the truth at the time. (pat26)

> Patients may seem fine but they put on a front and deep down they're scared and worried. I had two tumours in my neck but they [the doctors] didn't tell me about the second one [points to her neck, behind her left ear] until they'd got rid of the first one. I'm glad they didn't because I was so worried about the first one I don't think I would've coped if they'd told me about the second one, which was actually much harder to get to. (pat11, interview)

Some respondents gave anecdotal illustrations of how losing hope can have catastrophic consequences on prognosis:

> I had a friend who had a terminal disease, cancer, and the doctor told him he had 6 months to live and he lived 5 days! He had a very pessimistic nature. The doctor shouldn't have said anything, but discussed it with the next of kin. (pub34)

One member of the public recounted the story of her grandmother:

> When my grandmother [...] was in hospital, she overheard something being said about another patient and she thought it was being said about her and she gave up. (pub10, interview)

Conflict between hope and truth-telling

Although maintaining hope in the patient was widely considered to form part of a doctor's duty, respondents acknowledged that it could conflict with other duties:

> [The] doctor has a responsibility to maintain hope (state of mind half the battle) but if the patient wants to know this level of detail then they have made their own decision about what information they need to face the future. (pub4)

The tension between a doctor's duty to inform and his duty to maintain hope is evident in the answers of many respondents. One way to resolve this tension is through the use of the doctor's communicative ability, which may allow him to disclose the necessary information in a hope-maintaining manner. Ideally, the doctor will find ways to discharge both duties since fulfilling one duty at the expense of the other is potentially harmful. One SHO said "The right moment [to disclose bad news] is when you can tell the truth while at the same time keep some hope in the patient. If you can't do that, you shouldn't break bad news. You should wait until the right time comes".

Another warning on the potential hope-extinguishing effects of disclosure was made by one GP (GP17), who wrote: 'I have in the past answered more directly than I do now about (say) life expectancy, which destroyed hope'. In an opportunistic interview, a retired GP described how, as a very young doctor in the 1960s, he treated a protestant minister suffering from an aggressive bowel cancer. The doctor in charge, who estimated two weeks would elapse before the patient's death, suggested giving increasing doses of painkillers until the patient died, all the while pretending that the injections were antibiotics needed to treat an

'infection'. The patient's wife knew about the deception. The GP, unhappy with the consultant's approach, decided to discuss the situation with the wife. She agreed to let him reveal the diagnosis and grim prognosis to her husband. When told, the minister went "absolutely mad, refusing all treatment and all painkillers". The patient became convinced that he was destined for hell. The GP said "It was horrible. I can still see his face. To this day, I believe telling him was the biggest mistake of my medical career".

The GP's epistemic self-criticism may well be misguided. The moral evaluation of his decision to disclose should not be assessed retrospectively by examining the outcome, but by judging the nature of his intentions and whether his expectations of the patient's reactions were reasonable given the evidence available *at the time*. Nonetheless, the case demonstrates the potentially devastating effects of truth on a patient's well-being and the importance of judgement in resolving truth-telling problems.

The non-specificity of hope

One cancer patient who was deeply involved in her local cancer support group commented:

> Some people do recover when the prognosis is poor (mine wasn't all that marvellous) and hope should not be stifled. But sometimes hope is not about physical recovery, but about achieving goals: seeing a grandchild, a last holiday, or whatever. You can say 'I hope you will feel better soon' when you know someone is dying: feeling better may be healing into death. Feeling better is not getting better. (pat52)

Oncologist 1 (interview) also mentions the plurality of referents for hope:

> [...] in terms of removing hope, you know it might be that the information that you give will take away the hope of survival, but it shouldn't take away the hope that their condition will be managed as carefully and sympathetically and as effectively as possible, that you should give them hope that their pain will be controlled and they will be supported and their family will be supported. These are hopes that, that you can instil even at the same time as taking away hope for survival.

Hope requires a specific referent (i.e., one hopes for something) which need not necessarily be physical recovery, although it is usually meant as 'hope for

recovery'. As the respondents above pointed out, hope can also be directed at other things. This is consistent with the findings of Benzein, Norberg and Saveman who found that terminally ill cancer patients do not merely hope for a cure but for a 'normal' life, for a good death, and for rich relationships with themselves and others[282].

One neurologist (neuro02, interview), a firm believer in the importance of hope, described how he would attempt to lift the spirits of a patient diagnosed with motor neurone disease and his wife:

> Some box it [the disease] up and refuse to confront it with even partners. You can tell when they come in, they sit facing different ways even though they're next to each other. So, sometimes, I start by telling them that even though there are only a few years ahead, many patients find these years emotionally rich. While most couples argue about white or brown bread, they focus entirely on their emotional life. They stop dealing with those quibbles. That may be seen as deception as I don't know how that particular patient will deal with it, but I think it helps.

So here the hope is not for recovery but for an emotionally fulfilled end to one's life where the trivialities of 'normal' living are replaced by a richer, more meaningful content.

The non-specificity of hope is also alluded to by a palliative care doctor who stressed the shift in the patient's hopes and the doctor's duty to prompt this shift:

> Patients shift their hope from cure, to control to comfort, such they can maintain hope even in the face of death. Patients can be helped to make that shift with care, support and a safe environment. A few still struggle to make the shift and prefer denial. (doc25)

Several respondents made an explicit link between hope and recovery. Pat46 favoured doctors' benignly intended deception on the grounds that 'someone with a positive outlook can overcome so many things', while pub29 wrote 'any hope for the patient may keep him alive. Without hope, they may just give up!'. A dermatologist (derm1, interview) also shared the view that hope can provide therapeutic benefits:

Interviewer: Do you think it could actually have an effect on recovery or prognosis?

Derm1: Yes, definitely, yes. I think many of these tumours are made in balance with immunological states trying to get rid of them, and a lot of pain and depression and those things can have a negative effect.

One elderly patient suffering from hypothyroidism expressed a similar thought when she said 'a benign lie can work in a way similar to a painkiller' (thy25), thus echoing Plato's analogy between lies and therapeutic drugs[164](382b-382d).

Yet some respondents believed that hope can be detrimental if it is too far removed from the realm of possibility, or unaccompanied by other informative comments:

> False reassurance can be quite dangerous [...] and I think that's when we go wrong sometimes. If somebody says "am I going to be alright?" and you say "yes, it'll all be fine", well that's in no way finding out what you're talking about. (GP1, interview)

> [...] false hope is a terrible thing because false hope for me means hope with the exclusion of reality. (SHO01, interview)

> I think to have some sort of hope is actually quite important, but it has to be tinged with realism, it has to be within the realities of the disease that they have. (neurosurgeon02, interview)*

Optimism as self-protection

Hope, then, can be deemed of great importance in fostering the psychological and physical well-being of the patient. However, it can serve another purpose. Softening the harshness of a poor prognosis can benefit doctors who, as one interviewee bluntly puts it, might otherwise 'top themselves' if constantly disclosing unequivocally bad news. One palliative care doctor, commenting on the case of the lethal mistake (case 4), wrote:

> I do not think I would have the strength to tell the patient that I was going to be the cause of her death in a matter of minutes. (doc26)

One GP wrote in her comments on the questionnaire:

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* For a brief philosophical examination of the distinction between hope and false hope, see appendix I (p.369).

> I wonder if some of my inherent beliefs in some forms of deception are ways of protecting me, as well as the patient, from the pain of disclosure and the consequences. (GP28)

The protection ensured by deception can be more complex than simply protecting the patient from an awful reality. Because the patient's pain is triggered by the doctor's disclosure, the doctor may feel somehow responsible for the chain of events that will ensue from the revelation. The 'pain' of disclosure can thus affect both the patient and the doctor. The feeling of responsibility for the patient's misfortune is an additional reason why deception may be considered protective.

Another instance of mutually beneficial deception is given by an oncologist, who described how she rarely informs patients of the best cancer treatment since it is unlikely that funding for the treatment will be obtained:

> So there's a deception there in the sense that you say to the patient, "look this is what's wrong with you, these are the treatments available", but you don't say to them, "this is the treatment, it's not available, it costs a lot of money" unless you really want to stir up a huge hornets' nest and make them uncomfortable. (onc03, interview)

The oncologist's later mention of the time limitations of consultations, as well as her discomfort in discussing this issue with patients, indicate that avoiding mention of this subject may protect both parties from the troublesome hornets. Towards the end of the interview, she specifically refers to the emotional difficulties of working in a system which cannot cope with the needs of patients.

> You have to sort of work out how you're going to cope yourself emotionally with working in a job where the resources are inadequate, [...] you're trying to treat patients and you have [...] your hands tied behind your back all the time. So how much are you going to be just point blank honest with the patient and share your worries and concerns with them, when actually there's nothing they can do about it, I don't know. That's for me the big area of deception in cancer care.

One of her colleagues (onc04) also said that he would withhold information about unavailable treatment, unless specifically asked about it by the patient. Like onc03, the oncologist alluded to the distress such a discussion would cause to himself and to the patient. Unlike his colleague, however, onc04 did not believe that this constituted deception:

> Yeah, I would say, I would say it wasn't deception because they're asking me what are the options here in this hospital and I would be putting forward the options that are there.

Another oncologist (onc5, interview) held yet another position on this issue. He claimed to disclose all the treatment options to patients "whether they're available in practice or available only theoretically" and believed a failure to indicate these options was 'deception'. He added:

> *Oncologist*: PCTs [Primary Care Trusts] don't like that. They would prefer us to keep our mouths shut. So they're into deception.
> *Interviewer*: Yeah?
> *Oncologist*: Big time.

This is another example of how respondents, even within the same medical specialty, can have different understandings of such terms as 'deception', 'truth-telling' and 'relevant truth', as well as different notions of what constitutes good practice.

When this issue was presented to a patient (pat10, interview), she said that she would feel deceived if the doctor failed to mention the unavailable option. She pointed out the possibility of collecting enough money to obtain the treatment elsewhere or to express her discontent to her MP.

Finally, doctors can deceive primarily for their own benefit. One dermatologist (derm1, interview) commented:

> *Dermatologist*: If you made a mistake and really put the patient at risk, you're not going to tell him the mistake you've just made.
> *Interviewer*: For who's sake?
> *Dermatologist*: For your own sake, you have to. For example, when I was a student -- I think I was a student -- I was told to give a patient a needle with some heparin and on the tray prepared by the nurse there was more than just heparin, and I injected a big dollop of methyl alcohol and the patient went unconscious and then recovered. He said "That was a funny episode". I didn't tell him I'd injected methyl alcohol.

One neurologist (neuro1, interview) cited the (partly) selfish desire to avoid the unpleasant consequences of adverse disclosure as a reason for deceptive non-disclosure of information:

Interviewer: So would you say that one of the reasons, then, why doctors, neurologists deceive is partly for themselves, to avoid perhaps an unpleasant task of...

Neurologist1: Yes, and that may not be something they'd be willing to articulate and therefore...but you see it in operation all the time because if you say something to somebody that's ghastly, then you've got to deal with the consequences. If you don't want to deal with the consequences or feel you are unable to or feel you don't have the resources to, then that creates a situation which tends to promote lack of honesty.

At the end of the interview, he added that deception could prevent the doctor "from having to deal with patients sobbing in front of them or whatever else might happen".

"Passing the buck"

The experience of two cancer patients indicates that doctors may deceive to avoid disclosing bad news that they think should be revealed by someone else. Pat31, who was told by her consultant that the ultrasound showed her ovaries were swollen and her uterus distended, describes her encounter with him:

> I asked if he [the consultant] could tell whether it was serious and he sort of mumbled 'no' and shrugged his shoulders. Obviously didn't think it was up to him to tell me that I had advanced ovarian cancer! I had to wait over a week to see the gynaecologist and by that time I had already done some Internet research and diagnosed myself.

Four pre-registration house officers interviewed opportunistically on this issue believed that consultants and registrars had no excuse to withhold a test result, however awful. They did not believe that breaking bad news was the role of a house officer, however, and would not feel responsible for failing to inform a patient of a grim test result.

One patient with ovarian cancer (pat3) vividly described an instance when two doctors 'passed the buck' to avoid disclosing bad news in front of her. She recounted the time when she was told that there was a problem with her liver:

> There was a registrar and SHO standing at the foot of my bed and I'm sitting on the bed wondering what's going on and they're, they're saying

> "Well you tell her, you ordered the test", "No you tell her". (pat3, interview)

Buying time

One function of deception is to 'buy time'. Buying time may be desirable in three types of situation, which may occur simultaneously:

1. When the patient is deemed unable to handle the truth for psychological reasons
2. When the patient is deemed unable to handle the truth for medical reasons
3. When the current information is insufficiently accurate or informative and time is needed to obtain further results

Temporary deception to medically and psychologically fragile patients

Although the metaphors listed earlier were depictions of physical harm, truth-telling can be seen to cause considerable psychological damage which may, in turn, affect health. This was most clearly shown in the case of Mr Smith, where nearly all the respondents who opted to withhold the information from Mr Smith gave health-related reasons to justify temporary non-disclosure:

> No, I don't think he [the doctor] should tell him [Mr Smith] because it's going to hinder ... you're saying that he could have another heart attack? Well, no, it's like, say you were in an accident and your husband has been killed. You wouldn't tell the wife, "Your husband has been killed" until you felt that she was in such a state as to receive the news. [...] No, I don't think he should be told, not in the condition -- as you are putting it -- that he's in. (pub9, interview)

> I believe that doctors should be as honest as possible with their patients, particularly if asked a direct question. However the patient's immediate health should be a bigger priority and the only time a doctor could really be justified in lying would be if the truth is likely to put the patient's life in any sort of immediate danger (e.g., risk of another heart attack). (pat18)

One aforementioned SHO said that the doctor "should wait [to disclose] until the right time comes". The 'right' time, however, does not always come. It may never present itself despite a doctor's efforts to create an opportune time. A palliative care registrar emphasized the importance of progressively imparting bad

news. "I ask questions like 'what do you think about your diagnosis? What do you think it could be?'". Usually, the patient will utter the word (e.g., 'cancer') so carefully avoided by the doctor. Sometimes, however, the patient simply has no idea. In some such cases, the registrar said that she sometimes did not inform the patient. One oncologist described how she would disclose a diagnosis of cancer to a cancerophobic patient: "gradually in stages, so first of all you tell him he's got a lump and then a little bit later you tell him that it could be cancer and then when he's had it out you tell him that it is cancer, so you're not telling him right away 'you've got cancer'" (onc01, interview). The bad news is thus disclosed incrementally to psychologically prepare the patient for the full extent of the bad news.

Although deception could be designed to allow patients to psychologically prepare themselves to receive bad news, it could also be used to delay a disclosure which might ruin certain projects or ambitions. A good example of this is given by a GP:

> I remember one elderly patient who absolutely loved opera. His dream was to go to Milan to hear, well, I don't know exactly. He'd saved up for months to go there. He wasn't feeling well so we did blood tests and what the results showed was that nearly every organ in his body wasn't working. So when he asked whether everything was all right and whether he could still go to Milan, I said "yes, everything's all right and you can still go to Milan. We may have to do a few more tests when you return but you're fine now". He went off to Milan and had the time of his life. Later, when he was feeling very poorly, he said to me "you knew things weren't all right, didn't you? You knew from my blood test. You did the right thing". (GP, interview)

One haematologist (haem1, interview) stressed the importance of having a relative present when breaking bad news to a patient. In order to arrange this, he would regularly lie to the patient by saying over the phone that the test results were due back tomorrow and organising a consultation for the next day. In fact, he would already have the results. The lie minimised the likelihood of the doctor disclosing grim news over the phone and increased the chances of the patient bringing along a relative to the consultation. In his words:

> When I do lie to patients is that I'll say "We're getting the result tomorrow", sometimes I have a result and then I phone them up and I say "We expect to get all your results by tomorrow and therefore I wonder whether you can come in and see me" [...] I don't want to give them news

> on the phone [...] and then the other thing is people will usually bring a relative in for that sort of meeting spontaneously. (haem1, interview)

The deception is not aimed to buy time, but rather to optimise the conditions for disclosure.

Temporary deception to verify accuracy of information

The third situation was mentioned by a house officer in a telephone interview. He provided a real-life example of a patient with an abdominal aortic aneurysm ('triple A') who underwent a chest X-ray before the operation. Although the medical team believed he had a good prognosis, the radiologist saw a 'suspicious' long shadow suggestive of cancer. They performed a CT scan of his chest without informing the patient of their suspicion. The scan revealed a harmless old scar.

One cancer patient believed the temporary withholding of a likely diagnosis was acceptable in cases when there is a prolonged wait for the test results. The psychological trauma of a possible adverse diagnosis would otherwise hang over patients like the sword of Damocles:

> Well if you've got four weeks of investigations to go through and then another couple of weeks to find out the results, you know, people are likely to get through that time much more easily if somebody says "Well, we just need to check this out, you know, it probably isn't but we do just need to make sure it isn't". (pat3, interview)

Non-doctor views and reasoning on doctors' control of information

Miyaji's study showed that doctors have many ways of controlling the information given to patients. Her study, however, did not ask non-doctors what they thought about the moral acceptability of 'tailoring the truth', as one respondent put it.

The present findings suggest that many non-doctors also believe that doctors should control the amount of information they give. They may recognise that doctors can disclose unwanted information with harmful consequences to patients. Many stated that doctors should truthfully answer questions *asked* by the patient

but allowed them to withhold information that they considered potentially distressing or harmful.

Pub53 writes that deception may be acceptable if 'no direct question has been asked and a doctor believes that the patient could not cope with the information'. This view is echoed by an HIV/AIDS patient (pat12) who commented:

> This experience taught me that if I ask a direct question of a doctor I expect his honest answer. Otherwise, I may find out that my doctor lied to me and would no longer trust him. But I feel that if the doctor believes that releasing certain information to a patient without being asked [sic] then the doctor has the right in the patient's best interests to withhold certain information.

The findings reveal an underlying agreement amongst members of each group: that doctors are justified, at times, in withholding potentially damaging information from patients.

Conclusion

To summarize, I derived four broad categories from the data relating to the functions of deception:

1. Humane deception
2. Hope-maintaining or hope-enhancing deception
3. Buying time
4. Protection of the doctor

The categories are not mutually exclusive. Indeed, there are cases where deception is used to achieve all four goals at once. In the case of Mr Smith, for instance, deception may have been justified by appealing to 'humane' reasons not to disclose, a duty to maintain Mr Smith's hope for a full recovery, an intention to wait until his blood pressure stabilised before disclosing, and protecting the doctor from answering uncomfortable questions. As humanity and hope are central to the ethical practice of medicine, we should perhaps not be surprised if benignly intended deception has been -- and may still be -- entrenched within the doctor-patient relationship.

CHAPTER 10

Mutual Sharing of Information between Doctors and Patients

One of the last questions in the survey was 'Do you think a doctor and his or her patients should know what each other's views are on these issues (i.e., truth-telling and benignly intended deception)?' It was hoped that this question would shed light on the desirability of developing a system enabling doctors to tailor the amount of information to the preferences of the individual patient.

To the best of my knowledge, the idea of taking an 'ethics history' originates from Raanan Gillon's *Philosophical Medical Ethics*, in which he proposes that patients be offered a questionnaire upon first registering with their doctor or attending a hospital, asking them 'in advance their views on being deceived about unpleasant news, and indeed on a whole range of medicomoral issues'[155](p.103).* Variants of the idea have since been implemented, in the form of a survey, in several hospitals and hospices (Murtagh F, personal communication, August 17, 2005)[283]. Murtagh and Thorns, two doctors who work in palliative care, regularly offer patients an 'ethics history sheet' upon admission to the clinic. The sheet is a two-page survey asking patients how much they would like to know about their condition, whether they want family members to be involved in the decision-making process, and whether they have preferences for or against specific treatments.† A study (due to appear in a forthcoming issue of the *Journal of Medical Ethics*) showed that use of this ethics history sheet improved patient satisfaction and doctors' confidence in disclosure in the palliative care setting[129]. Compared with a control group of 61, the 40 patients who completed the questionnaire were more likely to:

a) have been happy with the amount of information given (Control group (CG) 73.8%, Intervention group (IG) 87.5%)

b) have been happy with the way information was given (CG 80.3%, IG, 97.5%)

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* The idea of doing this PhD also originates from my reading of this particular passage.
† A copy of the 'ethics history sheet' can be found in appendix J (p.372).

c) feel that their family or carer was kept informed as they wished (CG 60.7%, IG 92.5%)

and

d) feel confident that future decisions about their care would be made in their desired way (CG 72.1%, IG 87.5%)

Although a) through d) showed improvements, only b) and c) achieved statistical significance at the 5% level. From the doctors' perspective, the tool significantly improved doctors' confidence in matching information to the patient, involving the family in patient care, knowing how involved patients want to be, and matching future decisions with patient preferences. In their conclusion, the authors suggest that this tool should be adopted not only in the palliative care setting, where doctors are likely to have greater contact with patients and therefore a better idea of their preferences, but also in the more impersonal, acute hospital wards.

The results of my questionnaires (see table below) also suggest that the majority of respondents in each group are in favour of sharing information on the issue of truth-telling.

	Doctors (n= 83)	Patients (n=87)	Public (n=55)
Yes (%)	67	74	73
No (%)	11	14	13
I don't know (%)	22	13	15

Table 10: survey results for question 'Do you think a doctor and his or her patients should know what each other's views are on these issues (i.e., truth-telling and benignly intended deception)?'

The data thus support Hagerty *et al.*'s recent systematic review of communicating prognosis to cancer patients, in which the authors conclude:

> [...] many [cancer] patients would like the specialist to check with them first if they want prognostic information and what type of information they would prefer, such as the probabilities of cure, survival rates, general expected outcome of the disease[14](p.1006).

In my research, respondents presented a wide range of arguments for and against the idea of mutual sharing. These are described below.

Arguments in favour of mutual sharing

Tailoring information to the patient

As patients differ in how informed they wish to be about their condition, doctors need to tailor their disclosure to the individual patient. Failure to disclose important information is not the only way to disrespect patient autonomy. It is also possible to do so by disclosing *more* than the patient wants to know. One dermatologist said:

> But as far as I'm concerned, I want the doctor to take over, entirely. I'm not that keen on having to make decisions myself. [...] I don't want to be burdened with huge amounts of detail that I have to make decisions with. (derm1, interview)

Either way, the patient's informational needs are not respected if he receives too little information or if he is overloaded with unwanted details. Doctors are likely to agree that the nature of the disclosure should ideally match the desires of patients. Part of the doctor's role, then, is to ascertain what these desires are in order to act in the best interests of the patient (see 'doctor as explorer' in chapter 8, p.224-231). The mutual imparting of information regarding truth-telling can greatly facilitate this task. Although it may not remove all doubt, information sharing can minimise the misunderstandings that can arise when decisions are based on conjecture or habit. Patient 11 (interview) said:

> I think it [the ethics history sheet] would be useful for me and the medical staff because they would have a far better perception of what, what I feel, you know, and how far they can go with me and what, what courses they could pursue.

Below are illustrative comments by two patients, one suffering from severe multiple sclerosis, the other from advanced HIV/AIDS. The extracts highlight the dangers of assumption and the variability of positions regarding disclosure.

> Doctors are not mind readers and deal with many people with many different points of view. Doctors cannot be expected to guess at what a patient would or would not want to know. If this is cleared up in an initial consultation then a doctor has a better chance of doing what's right for his/her patient. (pat15)

> It's fundamental to have trust and mutual understanding on this issue. Too often doctors assume what is in the best interests of the patient without discussing it and make totally unfounded judgements about individual patients' ability to deal with medical information. (pat36)

The limitations of relying on assumptions were mentioned by one oncologist, who recognised that occasionally doctors misjudge the informational desires of patients:

> *Interviewer*: When you're wrong, you mean, either you've told them too much or not enough or...?
> *Oncologist*: We've completely misjudged the situation as to whether they wanted the information or didn't want the information and, just occasionally lines of communication completely break down with patients because you've blown it. You've either told them too much -- you've told them things that they didn't want to know -- or you haven't told them things that they did want to know. (onc05)

Given the difficulty of gauging the desired levels of information based on often short and infrequent consultations, a questionnaire may reduce the likelihood of misjudgement.

Sharing as empowerment

Knowledge of one another's position on the issue of disclosure may not only be beneficial to the doctor, but can also *empower* the patient by giving him more control over information.

> If you know under which circumstances you might be deceived, you can trust, choose not to challenge or insist on the truth as you wish. (pub16)

> Greater knowledge empowers patients more, and offers them a greater opportunity to press for the truth if they think it to be in their best interests. (pub17)

'Knowing where you stand'

Mutual sharing may remove the moral wrong of deception by establishing prior consent to the 'deceptive' acts. As I discussed in chapter 3 (p.43-45), a common philosophical objection to deception is that it violates the autonomy of the patient and treats the patient as a mere means. Nevertheless, deceiving patients who have consented to deception would represent *respect* for these patients' autonomy and a respect for them as ends-in-themselves.

Discussing respective positions on truth-telling can foster trust by establishing some ground rules and, as some respondents said, "knowing where you stand".

> For a patient-doctor relationship to work effectively it is important that both work from the same ground rules. (pub35)

> I think both parties should 'know where they stand' with each other in this kind of situation. (pat1)

The primary benefit of the idea of mutual sharing is the possible reconciliation of views between doctors and patients regarding the disclosure of information. Doctors and patients would operate on a common understanding of what should or should not be told, reducing the detective work sometimes required of both parties.

Clarifying the role of relatives

Another advantage would be to notify doctors of patients' wishes to have relatives informed of their condition and, in cases of prospective inadequate autonomy, to have named relatives make treatment decisions on their behalf:

> But asking [for names of relatives] specifically here is very helpful because it means that when they do become quite poorly, they've already got that permission and it's recorded. (onc02, interview)

The exploratory role of doctors described in chapter 8 (p.224-231) would probably be made easier. In that chapter (p.228), I showed that patients may not respond to the cues of doctors. Patients may be too shocked or tired to ask questions, may be intimidated by their doctor or may not feel sufficiently knowledgeable about

medicine. Alternatively, they may come from a culture where questioning a doctor is socially unacceptable. Finally, they may dislike their doctor or simply not suspect that anything is wrong. These reasons make the exploratory process difficult for both parties since there will always be some doubt as to *why* the patient is not responding to a cue or why the doctor is not disclosing certain information. Is the patient silent because he genuinely does not want to know or because he feels it is inappropriate to ask a question? Sharing information about disclosure at the outset may reduce the uncertainty inherent in consultations.

A minority of respondents were *against* the idea, or at least expressed some scepticism about certain aspects of the idea. Their arguments are summarized below.

Arguments against, or questioning the value of, mutual sharing

Variability of views over time

One frequent criticism amongst sceptical doctors is that patients may change their views as the circumstances change. This would require a regular update of the questionnaire, which may complicate rather than facilitate the doctor's task. Illness affects people in ways that cannot always be predicted *ex ante*. This thought is neatly captured by the statement of one GP:

> You know, until you've had a stroke and you're doubly incontinent you might have been saying I want all the treatment available to prolong my life but right now you might want to just chuck it in and die. Do I want to be in hospital? No, absolutely not, I absolutely don't want to be in hospital. Do I want to see my wife have chronic back pain from trying to lift me, in that situation the answer comes from a completely different place. You have to have this conversation with the patient every time you talk to them, that's what palliative care is all about and this would be an excuse for not having to have those conversations. It would be a way of fudging, but I think it's a great questionnaire for starting off a relationship with a patient. (GP1, interview)

GP1 raises another objection to questionnaires, namely that they could be used as an excuse to avoid sensitive conversations about the issue. This could be a deliberate avoidance or a subconscious decision to evade the issue. Such a tool

may lead to self-deception, whereby the doctor convinces himself that there is no need to discuss the matter further. Both of these possibilities are undesirable.

> The excuse would be: it would be collusion with a piece of paper, because oh, well, six months ago they said that, so we don't actually have to ask that difficult question because we've asked it already. (GP1, interview)

The central idea is that an excessive reliance on the patient's questionnaire may result in less attention to the patient's *current* views. As a patient's views may change as the illness evolves, doctors cannot rely solely on past directives to make decisions about a potentially quite different present situation. One member of the public points to the problems this may create:

> However, implementing this [the mutual sharing] would be a nightmare! It could leave doctors even more confused about what to tell patients and when, as it is unlikely that patients will be so specific describing their views on these issues to cover all eventualities. (pub36)

Although their scope will be limited, it may be preferable for patients to give clear and specific directives as well as the names of proxies to provide concrete guidance for doctors. Otherwise, the directives may confuse rather than clarify. If a more general directive is given, it is particularly important that the patient nominates proxies in advance to interpret and clarify any evaluative terms. More than one proxy would ideally be appointed, although a principal 'decision maker' should be specified to avoid intractable disagreements between proxies.

Of course, the specificity of the directives and the appointment of proxies would not obviate the need to re-visit regularly the informational preferences of the competent patient. Taking an ethics history should merely be the start of an ongoing process.

Emergency situations and other logistical concerns

Another limitation of mutual sharing is that it requires time. Doctors and patients need to establish their views through dialogue. In certain cases, such as in emergencies, there is no time to ascertain a patient's views on the issue of truth-telling.

> [mutual sharing of views on truth-telling] is a novel idea, and may clarify some very muddy waters. But [it is] not practical for acute and emergency situations, or where there is no prior opportunity or no previous relationship between doctor and patient. (doc9)

One GP questioned whether there was enough time for a dialogue on the issue of disclosure in a normal consultation. In a system that typically limits consultation times to a standard ten to fifteen minutes, there may simply not be the opportunity to discuss such matters while also treating the clinical problem.

> In ten minutes?????? [respondent's written multiple question marks] It [mutual sharing] would be a nice luxury but the process of practising safe and effective clinical medicine must come first. (GP20)

Hospital-based doctors also alluded to time limitations making it difficult for doctors to read the forms and to help patients complete them. One oncologist preferred asking the patients a direct question such as "do you want any more information?" before moving on to the next patient. Another said "if I had the time I'd spend three or four times as much time with my patient. There's a real premium on time." (onc05). Onc05 believed oncologists would welcome the idea if *other people* ensured the forms were completed.

One haematologist expressed another logistical concern:

> I think the spirit of it is very good, to be honest with you. Would I want to have it and start using it? No (sighs). Why is that? I think it's partly because...I mean look, these are notes of, volume two, that is of one patient we're looking after and we have so many pieces of paper that I try to not generate paper unless we really have to and I think that we can assess some of this in a way but it would be quite useful. I would be interested in using this as an audit for a temporary period and see how people get on with it.

Some doctors were not sure how the information would be exchanged.

> I don't know how you would go about doing this. (doc23)

> Don't know how it could be conveyed in a valid manner. Each situation is different and judgements are made on an individual basis. (doc37)

One cardiac patient commented on the difficulty of completing a form or answering questions in the midst of illness. For this patient, the doctor's job was simply to make her better.

"I want to know everything"

Some doctors questioned the possibility of providing 'all' the information to patients who request it. Onc05 said:

> "Do you want all the details?" Well, does that mean, you know, the direct prognosis, the side effects of every drug in detail, like percentages? No, I mean, we could put out a chapter from a textbook on, to know all the details! (onc05, interview)

A doctor will always be required to use his judgement, even if patients explicitly say they want to be told everything. Indeed, one haematologist claimed that he might override the wishes of a patient who did not want to know anything:

> But do I let them [patients] get away with not knowing? Not really, not at all because if I think if someone's going to probably die in the next three months they need to know that they're going to die soon, it's not fair to them, it's not fair to their family. (haem1, interview)

In short, the wishes of the patient may run counter to the doctor's judgement of what the patient should know in the circumstances.

Interpretive truth

While some patients may want to know 'everything', others may declare that they wish to know nothing. The danger of respecting this wish is that it may disguise an underlying desire to know, which the patient, through fear, self-denial or some other reason, does not express. One neurologist alluded to this risk:

> The first question is, I suppose, ok: "do you prefer not to know?", but [...] that may carry a number of meanings to it. (neuro1, interview)

Although the outward request is one for non-disclosure, the 'interpretive' truth may be that the patient wants to know more than he asserts[148]. A survey may not be sufficiently nuanced or probing to detect this deeper desire. The 'explorer's' communication and interpersonal skills will be necessary to elicit the patient's true preferences.

Trust in the doctor

Some respondents argued that merely discussing the issue may erode trust between doctor and patient. The unspoken assumption of truth-telling is put into question by the conversation and may raise doubts in the patient's mind about the doctor's honesty.

> If patients knew, they would find it hard to trust their doctors, and might always assume worst-case scenarios, thus making the situation worse. (pub10)

This is not supported by Murtagh and Thorn's study investigating the usefulness of an ethics history sheet[129]. The study showed that patients who completed the form were more confident that future decisions about their care would be made in their desired way. One type of trust -- trust in the appropriateness of future treatment -- thus seems to benefit from an ethics history sheet. Whether, and to what extent, the other referents of trust (including general trust in the doctor *qua* doctor) are affected is open to question. Of the 101 patients questioned in Murtagh and Thorn's study, two were distressed during the questionnaire, although the authors attribute that distress to the hospice admission rather than to the questionnaire *per se*[129].

Self-defeating aspect of consensual deception

Deception, whether in the form of verbal assertions or placebos, may in some cases achieve a therapeutic effect on patients, or at least raise their spirits. Yet the process of sharing views on truth-telling, some respondents claimed, might destroy any benefits of deception. Since deception relies on the expectation of truth, anticipating even rare untruths might jeopardise both the success of deceptions and whatever accompanying benefits they may carry. A few respondents thus argued that the idea of mutual sharing of views was self-defeating since the very discussion would negate the potential benefits of the deception.

> Having the patient know could destroy any benefits of the deception and also undermine faith in non deceptive cases, but I am also tempted by the idea of

> letting them know. I just don't know the actual consequences of each policy. (pub1)
>
> Yes [the idea is good], but it's not practical as this defies the ability to deceive!
>
> (pub23)

Mutual sharing today

In some respects, mutual sharing is already occurring in consultations. As I described in chapter 8, doctors have ways to elicit information from the responses or, indeed, the silences of patients:

> Well I think it's [the ethics history sheet] very good, I mean I would normally get this sort of information out of a consultation when I'm talking to someone, I will try to figure out how much they know, what they want to know. (onc01, interview)
>
> I work in an Irish setting and some elderly patients in particular do not want information, they leave it to their families or up to the medics -- I would usually ask a patient "are you the type of person who wants to be informed of all test results, or would you prefer for us to speak to one of your family?" -- I would try to have this conversation before there was particular bad news to break. (doc26)

The questioning, direct or indirect, by doctors may be more subtle than the one suggested by doc26.

> When I see a new patient with cancer I try to ascertain their requirement for information and likely coping strategies. The amount of information given and the way it is imparted is then adjusted appropriately (as best one can). (onc02)
>
> So I think I put a woolly question or a woolly statement in their court and wait to see if they'll elaborate and I don't think that is unethical. (GP1)

The subtlety of such interrogations means that the doctor needs to interpret the patient's replies and comments. Interpretation, however, is error-prone. Kutner *et al.*, in their study of the informational desires of terminally ill patients, found that 'few easily identifiable patient characteristics were associated with expressed concerns or needs, suggesting that physicians need to individually assess patient needs'[278](p.1341). Not only are patients' needs difficult to unearth, they also

evolve. The changing nature of needs would require a regular reassessment of patients' views.

Conclusion

Based on the encouraging results of Murtagh and Thorns's preliminary study and the widespread agreement in each group that mutual sharing on the issue of truth-telling would be desirable, a more structured, explicit method of gathering the informational needs of patients is worth considering[129].* The questionnaire format, completed by patients *in conjunction with* doctors and supplemented by regular opportunities to review their responses, may reduce doctors' reliance on assumptions and 'very subtle cues' (onc01, interview). This would allow doctors to more accurately tailor information to individual patients.

Since the healthcare system operates under financial and logistical constraints, the likely advantages of mutual sharing detailed above would have to be balanced with the costs (including the opportunity costs) of implementing the idea. Clearly, more empirical research needs to be conducted to evaluate the benefits and burdens of an 'ethics history sheet'. The present research hints, however tentatively, that such a transparent method of mutual sharing may, on balance, be beneficial to the doctor-patient relationship.

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* It is also encouraging that Dr Murtagh, who kindly read a draft of this chapter, remarked that the comments had 'a lot of resonance with the clinical experience I have had, and with what we found during the implementation of our research' (Murtagh F, personal communication, August 18, 2005).

CHAPTER 11

Conclusions and Implications

This final chapter is broadly structured around the four primary aims of the thesis. These were:

1. to review and evaluate arguments in the literature on truth-telling and deception, both generally and in the medical context

2. to examine empirically the views and rationales of members of three major stakeholders (doctors, patients and members of the public) on the issue of truth-telling and deception using qualitative research methods

3. to make practical suggestions to help doctors in their everyday practice and reduce potential conflict between doctors, patients and the general public

4. to assess the interplay between empirical research and theoretical bioethical debate, and relate the arguments and other rationales emerging from the empirical research to the existing philosophical/bioethical literature

These sections are followed by a discussion of the implications of the research for social science and bioethics methodology, a self-critique of the study, some suggestions for further research, and a final conclusion.

1. Review and evaluation of arguments on truth-telling and deception

The first five chapters of the thesis clarified the concepts of lying and deception, examined much of the literature on truth-telling and deception in philosophy and bioethics, rebutted absolutist rejections of lying and deception, and provided an overview of the historical and cultural dimensions of truth-telling in medicine.

After highlighting the complexity of the concepts of lying and deception, I evaluated various well-known positions on the morality of deception and lying (in chapter 3). Two types of tension were identified from the literature. The first was between absolutists on lying, notably Augustine and Kant, and non-absolutists, ranging from Grotius to Bok. I argued that the absolutist position, understood as the belief that lying is *always* morally wrong, can be countered by critically questioning the validity of the rationales underpinning the absolutism. Thus Augustine's theistic assumptions

about the teleology of language and its purported necessitation of an absolute prohibition of lying can be rebutted and Kant's apparently absolutist rejection of lying can also be rebutted using his own Categorical Imperative (CI), which can be interpreted in such a way as to permit lying and deception in certain circumstances. Although Kant may arguably have been an absolutist opponent of lying himself, lying need not violate Kant's own Formula of Universal Law if the maxim is sufficiently specified, nor the Formula of Humanity if interpreted in a 'Parfitian' manner. In sum, I argued that the moral justification of some lies *can* be universalised and need not entail treating others as 'mere means'.

Furthermore, I argued that even committed absolutists have ways to justify exceptions to their absolute prohibitions against lying (for example, by appealing to the doctrine of mental reservation or adopting a loose definition of lying) or that, at the very least, they accept that lies fall within a broad spectrum of moral badness, ranging from the abhorrent to the easily pardoned.

The second type of tension concerned the relative weight to be given to non-absolutist obligations about lying and deception. I examined how different moral theories -- deontological, utilitarian, contractualist, rights-based, virtue-based, and particularist -- could analyze the morality of lying and deception. Concluding that no single theory plausibly captured all the moral dimensions of deception, I favoured an intuitionist, pluralist approach combining a 'particularist' context-sensitivity with deontological, consequentialist and virtue theoretic elements in order to evaluate the acceptability or otherwise of deception in various circumstances. It appears from the empirical study that many respondents also adhered to a form of moral pluralism, albeit a seemingly messy one, and that an absolutist rejection of deception, however understood by the respondents, is the view of only a minority of the people I questioned, doctors and non-doctors alike.

The analysis of the data showed that terms such as 'deception', 'honesty' and 'telling the truth', which are often taken for granted in the literature and in ordinary language, are semantically unclear. A discussion of this instability, which has been noted by some linguists, appears to be absent from the bioethical literature[21 38]. This illustrates how social science research -- and interdisciplinary collaboration more generally --

can enrich bioethical debate. I argued that without an agreed definition of terms such as 'deception', we run the risk of inadvertently and misleadingly muddying the moral waters through a sloppy use of language. Considering the difficulty of defining concepts such as 'deception', it may be desirable in morally contentious cases to substitute these terms by clearer explanations of the acts and omissions in question. This would disentangle the normative and descriptive elements in the exposition of the acts or omissions and allow ensuing moral analysis to be based on an initial non-evaluative description.

Chapter 4, combined with the empirical results, revealed yet another apparent tension between, on the one hand, the dictums of the various codes of medical ethics which in recent times summarily require honesty and condemn deception and, on the other, doctors' estimates of the prevalence of deception in medicine, which many deemed to be high. Either the doctors' estimates are grossly wrong or many doctors are, according to the codes, acting unethically. In the present study, I have argued against absolute prohibitions on deception and would attribute the discrepancy primarily to the unrealistic nature of the codes of ethics. I argued that although deception and lying are *prima facie* wrong (since they *tend* both to restrict the deceived's freedom to choose autonomously and to undermine overall trust in the deceiver) they are not absolutely so.

In chapter 5, I traced the historical evolution of the truth-telling debate in medicine, from Hippocratic times to the present day. Many of the arguments in favour of benignly intended deception, from maintaining hope to therapeutic necessity, have remained unchanged from the ancient Greeks. Throughout the history of Western medicine, doctors commonly withheld potentially distressing information. Although a major shift in favour of disclosure seemed to have occurred in the 1970s in the United States, the trend was far from universal[180]. Until 1989, the Italian Medical Association's Code of Ethics read: 'A serious or lethal prognosis can be hidden from the patient'[186]. In some countries, disclosure of cancer is still the exception, rather than the rule[184]. A broader perspective on the issues of truth-telling and deception, both in time and in space, can illuminate our own approach to these issues by raising awareness of context and culture, and the role that these play in ethical analysis.

2. Exposition of views and rationales of doctors, patients and members of the public

The empirical side of the study (chapters 7-10) aimed to gather the views and reasoning of members of three groups of 'stakeholders'. It also served to identify some neglected issues and ideas in the theoretical literature and either support or reject the empirically testable arguments of philosophers and bioethicists.

In chapter 7, I found that people's understanding of deception was not always stable, but could depend on their moral stance when evaluating a situation. Respondents were much more likely to call an act 'deception' if they disapproved of it, consistent with the unremarkable observation that for most people 'deception' is a negatively morally laden term. Their definition of deception would thus shift in order to avoid supporting the practice. This strategy enabled some respondents to avoid the conflict between the putative duty not to deceive and the duty to act in the best interests of the patient. Sometimes, the temporary nature of the 'deception' or the benevolent nature of the act absolved it from the offensive label. At other times -- and occasionally from the same respondents who used the 'semantic shift' strategy -- the label was kept but the moral value of deception ceased to be overwhelmingly negative. Deception became acceptable or desirable in certain circumstances.

Respondents could also be inconsistent in what they understood by 'telling the truth'. The phrase 'tell the truth' contains an important elliptical qualification: *relevant and reasonably expected* (i.e., 'tell the relevant, reasonably expected truth'). In my own analysis, doctors have a prima facie duty to disclose what they think is a) true, b) relevant to the patient's medical condition, and c) reasonably expected by the patient. Differences between the views of the respondents can generally be attributed to varying interpretations of b) and c). The conclusion drawn is that what is 'relevant' or 'reasonably expected' is not an absolute, immediately perceivable truth, but the product of an agent's value judgement as well as societal values. As such, people in the same community may disagree over what they see as 'relevant' or 'reasonably expected' and so may entire cultures. Thus the semantic content of 'truth' in the expression 'tell the truth' is not fixed. The first question that should be asked when someone asserts that "doctors should not deceive their patients" or "doctors should

always tell the truth" is "what do you mean by deception?" or "what do you mean by 'the truth'?"

To the best of my knowledge and following quite intensive investigation, the *concepts* of deception and relevant truth have hardly been explored in the medical and medical ethics literature. This research highlights the richness and complexity of these concepts. Commentators on truth-telling and deception in medicine have focused at length on issues of right and wrong but appear to have ignored the more fundamental definitional and epistemological problems associated with the key terms of the debate. Novack *et al.*, for example, in their seminal study on doctors' deception, provide a cursory definition of deception: 'to deceive is to make another believe what is not true, to mislead'[22](p.2983). They conclude the study by asserting that 'a better understanding of deception should lead physicians to a clearer articulation of the principles that guide their actions'[22](p.2985). This is quite true, but it is also the case that a better understanding of deception and truth-telling will help bioethicists make clearer moral assessments of these act-types.

Conclusions from empirical chapters (chapters 7-10)

In spite of the negative connotations of 'deception', a significant majority of each group adopted a non-absolutist position on doctors deceiving patients in their best interests. In the minds of many respondents the prima facie duty not to deceive could be trumped by other moral goods. Deception was deemed acceptable if it could protect the physical or emotional well-being of the patient ('humane deception'), if it could preserve or enhance hope ('hope-maintaining or hope-enhancing deception') or if it could buy time in situations where immediate disclosure would be harmful or unduly distressing. In this respect, the findings are inconsistent with those from Holm's study, in which he tentatively claims that the doctors and nurses in his sample viewed the patient's right to be told the truth as absolute[17](p.123-124). My research clearly shows that the right to be told the truth (understood as the 'right to be told relevant, reasonably expected information relating to one's medical condition') is seen as a prima facie right that can be superseded by other considerations. This is in

line with the views of non-absolutist ethicists such as Higgs and Thomasma[148 152]. If the absolutist stance is the 'right' one, few people in my research seem to abide by it!

However, when asked outright, respondents were generally far less permissive of lying than non-lying deception. For some, lying was absolutely prohibited even at risk of death for the patient. The greater stringency of the duty not to lie over the duty to tell the truth was explained in various ways:

1. Lying is intuitively worse than non-lying deception.
2. Lying is more likely to damage the trust between doctor and patient.
3. Lying is usually in response to a direct question. A direct question is likely to indicate a desire to know the truth.
4. Lying is more clear cut; one cannot claim "I didn't lie" if accused.
5. Lying tends to be more irreversible than non-lying deception and hence requires greater effort to correct the informational 'damage'.
6. Lying distorts reality to a greater extent than non-lying deception.

Although reasons 1 and 2 are often invoked in the contemporary debate on the issue, the other reasons are less frequently heard[6 29]. Some of the reasons for the difference between lying and non-lying deception are pragmatic: lying is more categorical and harder to 'fix' than other types of deception. This is particularly relevant in cases where doctor and patient hold regular consultations and have an ongoing relationship. As the patient's informational needs and desires evolve, what is best withheld at time X may not be at time Y. Non-lying deception leaves open the option of later informing the patient without obvious contradiction. The third reason -- that lying is worse because it is likely to deny the patient desired information -- probably stems from the dynamics of a consultation. As I discussed in chapter 8 (p.224-235), doctors and patients both attempt to satisfy their informational needs through verbal and non-verbal cues. Lying in response to a clear attempt to gather information is arguably more uncooperative than non-lying deception.* The difference here is contextual rather than based on any intrinsic properties of each act-type.

One interesting finding is that people's views on the moral distinction between lying and non-lying deception often change when applied to a particular scenario. Whereas

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* In general, I suspect this is true, but it is an open question whether violating the Gricean maxim of quality is *always* more uncooperative than violating any of the other maxims (e.g., the maxim of relevance). Empirical research would certainly help to answer this question.

people are likely to view lying as worse in the abstract, their evaluation changes when comparing the practices in a specific context. In the case of cancerophobic Mr Smith (case 6), over half the respondents believed that lying to Mr Smith about his cancer was morally equivalent to deceiving him without lying. In some cases, it appears that both lying and non-lying deception can be fuelled by the same intentions, have the same anticipated consequences, show the same degree of respect or disrespect, grossly violate the Gricean cooperative principle and equally restrict the deceived's freedom to choose autonomously. This lends some empirical support to Bernard Williams's view that, in some contexts, lying is morally equivalent to non-lying deception, although in many others lying is worse[35](p.108). However, it does cast doubt on Jennifer Jackson's claim that lying damages trust more than other types of deception:

> It is one thing to try to spare someone distress by concealing information or by trying to fob them off with a half-truth; quite another to do so with a lie. [...] Tolerance of lying, even trivial lying, is subversive of trust, in a way that deceiving and concealing need not be[6](p.84).

It may be true that lying *tends* to damage trust more, but the link is not a necessary one.* A 'half-truth' may damage trust just as an outright lie, and was perceived to do so by many respondents. The relationship between trust and types of deception may not be as straightforward as Jackson claims[195].

As I explored in chapter 4 (p.104-106), trust has various referents in the context of the doctor-patient relationship, ranging from trust in the doctor's technical competence to trust in his honesty. The impact of deception on each referent of trust and on what Hall *et al.* call 'global' trust (the overall 'feeling' of trust) is unclear, although the present study, coupled with other studies showing strong and widespread trust in doctors and historical evidence that doctors in the past retained patients' trust despite frequent 'economies with the truth', indicate that the popular view that overall trust and deception are incompatible may be mistaken[157]. Global trust in doctors can coexist with a certain amount of perceived benevolent deception. The respondents in this research acknowledged the moral complexity of truth-telling issues and, in some

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* In support of the position that lying tends to erode trust more than non-lying deception, we could argue that since lies are harder to conceal or rectify than other forms of deception, they are more likely to be detected and hence more likely to damage the doctor-patient relationship.

cases, were unsure themselves of the morally preferable action. As long as the truth bias remains and deception is used to fulfil benevolent functions, the other components of trust listed by Hall *et al.* (i.e., fidelity, competence, confidentiality and global trust) may not suffer so much that global trust is lost[157].

This seems less likely to be true, however, on an individual level. In other words, global trust is more likely to be adversely affected if individuals suspect their *own* doctors are deceiving them. So although people can trust doctors who benevolently deceive their patients *generally*, they may be less prepared to allow their doctors to deceive them. Nonetheless, amongst the members of the public in my sample, half of the survey respondents claimed that they would permit their doctor to benevolently deceive them.

Similarities and differences between groups

At the outset, I expected to find significant differences between the views and reasoning of patients and members of the public, on the one hand, and of doctors on the other. The findings reveal that, contrary to my initial hunch, the groups have much in common in their approach to benevolent deception in medicine. One notable similarity was the degree of uncertainty over a) the definition or understanding of deception and b) its moral acceptability in certain situations. Most respondents mentioned the difficulty of the subject matter, acknowledged the complexity of balancing competing moral goods, such as hope and truthfulness, and believed that, in some cases, the benefits of benignly intended deception could outweigh the benefits of truth-telling both in everyday life and in medicine specifically.

Another similarity was the shared role of doctors and patients as explorers. Doctors attempt to assess the suitability and extent of disclosure based on an evaluation of the patient's character, beliefs, life plans, informational desires, and so on. Patients, through direct or indirect questioning, attempt to extract information from the doctor about their condition and its likely evolution. Both parties share the common desire to find out more about the other and reduce their own uncertainty.

The empirical research also revealed some measure of agreement amongst respondents on the desirability of mutual sharing of information on disclosure. Most welcomed the idea of a more explicit discussion between doctor and patient on the issue of truth-telling. As well as a desire for a dialogue, I was impressed by the fact that nearly half the respondents claimed that the questionnaire had affected their views on truth-telling, suggesting that there may be an educational value to such discussions.

The research, however, did reveal some differences between the groups. One important finding was that doctors were not exclusively concerned with improving patients' health and did not always balance the harms and benefits of disclosure in terms of probable consequences. At times, deontological obligations were deemed more important by doctors than by patients and members of the public. In case 4, for example, doctors were more inclined to disclose information of a fatal error than patients. For doctors, the duty to tell the truth in case 4 outweighed duties to protect the patient from harm. For patients, the opposite was true. In case 6, where Mr Smith asks a direct question about his cancer, doctors were most likely to reject lying as a morally acceptable option, followed by patients and members of the public.

As mentioned earlier, another difference between the groups related to the self-asserted permissibility of doctors deceiving the respondent. Whereas half of the 'public' survey respondents claimed they would find it morally acceptable for their doctor to deceive them in their best interests, only a third of the doctors and a fifth of the patients I surveyed shared that view. This divergence may be explained by doctors and patients' greater awareness of the realities of illness and of the medical environment. Patient 2, who suffers from ovarian cancer, hypothesized that there would be differences between members of the public and patients:

> I think if you haven't experienced it [illness] you can only theorise about it, and you might change your mind -- and you might change your mind about how you want it done. (pat2, interview)

It would be worthwhile to conduct a longitudinal study to investigate any changes in views and reasoning following the transition from healthy member of the public to sick patient.

Conclusions about the use of benevolent deception in medicine

The main conclusions from the research can be summarized as follows. The concept of deception is nebulous and either needs to be defined or, more plausibly, needs to be replaced in certain cases by morally neutral descriptions of the acts in question.* Since people's understanding of the concept of deception is so variable and since most people seem to accept that deception (however they define it) is sometimes morally acceptable, it is unhelpful to label deception as absolutely wrong. Furthermore, by reflecting on arguments about deception in the philosophical, medical and bioethical literature and on the results of my empirical research into the views and reasoning of members of three stakeholder groups, I have argued that the 'null hypothesis' that doctors' deception (including lying) is *always* morally wrong is unjustifiable or, at the very least, implausible. Moral goods, such as the avoidance of death and severe suffering and the preservation of long term autonomy, may trump the strong prima facie obligation not to deceive.

However, in spite of the permissibility of some acts of deception (however conceived), such acts are generally wrong in the medical context as they tend to stifle the exploratory ability of patients and undermine the patient's autonomy while eroding the global trust between doctor and patient. Deceptive acts and omissions should only be performed with justifications sufficiently strong to counter the negative elements above, such as a justified belief in the patient's desire to be deceived, or probable, grave and avoidable psychological or physical harm resulting from a truthful disclosure. The vagueness of terms such as 'justified', 'probable' and 'grave' indicate the need and importance of careful judgement in decisions to withhold -- or lie about -- relevant, reasonably expected information.

The concept of 'judgement' is central to the issue of truth-telling and deception, as ethical problems on disclosure arise when duties or obligations come into conflict, for instance the duty to share important information with a patient and the duty to maintain hope. As these duties are prima facie, judgement will be required to

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* In chapter 2, I offered my own account of deception (p.25) and accepted Bernard Williams' definition of lying (p.30). Nonetheless, in morally contentious cases, I suggested it might be preferable to replace these morally negatively laden terms with more neutral descriptions of the relevant acts or omissions before making the moral evaluation (p.191).

establish the demands of the *final* duty in a particular case based on a critical assessment of the relevant features and the context in which they occur. Yet, even with good judgement and a thorough knowledge of the individual situation, some decisions will not result in a clear-cut decision. Isaiah Berlin, on the subject of choosing between incompatible values, conveys the idea of 'moral risk' inherent in judging between competing moral goods:

> The concrete situation is almost everything. There is no escape: we must decide as we decide; moral risk cannot, at times, be avoided. All we can ask for is that none of the relevant factors be ignored [...][284](p.202).

The haze of uncertainty surrounding some decisions suggests that certain ethical choices on truth-telling are genuine moral dilemmas, pulling with equal weight in opposing directions. Uncertainty, after all, is an expected, rational reaction to genuine moral dilemmas.

Whether the dilemmas are ontological (i.e., the competing moral obligations possess equal moral weight) or epistemic (i.e., although one moral obligation may be weightier than the other, the agent does not know which to fulfill) is of little importance in the face of radical, informed disagreement over right action and the observation that some truth-telling decisions are widely acknowledged to be extremely 'difficult' by respondents. Some decisions are, at the very least, *pragmatically* irresolvable even if we grant that there may be a truly 'right' answer not accessible to us fallible mortals.

Whether or not we believe in true moral dilemmas or disagreements, all will agree that it is desirable to minimise situations of great moral conflict. For those who are 'pro' dilemmas, each course of action will include at least one morally undesirable component. For those who reject the existence of dilemmas, the lack of normative clarity increases the likelihood of the moral agent selecting the wrong option. How, then, can we avoid, or at least reduce, the occurrence of such troublesome moral problems? And if we cannot entirely avoid them, how should we attempt to resolve them? This leads me to a discussion of the practical implications of the research.

3. Practical suggestions for doctors

In this section, I propose some practical measures, gleaned from the empirical and theoretical analysis, which may help doctors **a)** avoid ethically difficult situations involving lying and deception (e.g., by actively eliciting patients' informational preferences) and **b)** deal better with situations where lying and deception may appear to be morally justified (e.g., by using a 'deception flow chart').

Although the empirical research revealed that most people in my sample believe deception to be morally acceptable in certain circumstances, it also highlighted the variability of people's views on the issue. This lack of agreement should remind clinicians that automatic or unreflective responses to truth-telling issues may be undesirable. The study stresses the importance of communication (and communication skills) in elucidating a particular patient's informational needs.

The research also examined the *ways* in which doctors explore the informational needs and desires of their patients. One popular method was to ask open questions and introduce cues to allow patients to pursue them if they so desire. Doctors gather information in an indirect way, relying on active participation by the patient. This permits a disclosure tailored to the individual patient. The results of this study support Miyaji's empirically based observation that 'if patients don't ask any specific questions, many doctors interpret this as an indication that the patient does not want to know'[15](p.252). However, my research with patients strongly suggests that this approach is prone to error. Patients may not ask questions despite wanting more information. They may be shaken as a result of a prior disclosure (e.g., a diagnosis of cancer), may dislike or be intimidated by the doctor, may come from a culture when questioning doctors is deemed rude or inappropriate, or may be shy or worried about appearing ignorant. For such reasons, some patients may pursue other ways to uncover details of their condition, such as reading books on their illness, browsing the Internet for relevant websites, or joining patient support groups. Others may simply remain mute.

These findings indicate that doctors should make it easier for patients to ask questions. This could be achieved by actively *encouraging* patients to ask questions, reassuring

them that it is acceptable, and, if appropriate, referring them to trustworthy literature, websites or support groups. Openly sharing information about disclosure, perhaps through the use of a questionnaire similar to that of Murtagh and Thorns, is a promising and practical idea which may reduce the occurrence of problematic, even dilemmatic, situations described earlier[129]. Although the subtle approach of open-ended, leading or vague questions may work in some cases, it will not in others, particularly if the patient is emotionally fragile, poorly educated or from a different cultural background. Several patients mentioned the autonomy-reducing effects of illness and their impact on the ability to understand information (p.228). Doctors' current approach to information gathering may be based on unrealistic expectations of patients. My findings are thus inconsistent with the affirmation by Cassileth *et al.* that 'patients' preferences may be readily discerned by physicians who are guided by the patient's verbal and behavioral clues'[276](p.835-836). Based on my analysis, discerning a patient's informational desires is often a delicate and uncertain exploration process.

The study has also clarified the conditions necessary for doctors to justifiably deceive their patients. In figure 9 (below), I present a 'deception flow chart' aimed at helping doctors determine whether a proposed deceptive action (or omission) is morally justified. It incorporates findings from both the empirical and philosophical analysis and thus contains a list of justifications for deception, objections to lying and deception, and versions of the Publicity Condition and Parfit's Consent Principle. Of course, it does not obviate the need for judgement. The doctor will still need, initially, to ascertain whether his proposed action is a form of deception.* Later on, he may need to decide whether, in the circumstances, the justifications for deception outweigh the objections. Furthermore, the answers to the questions (in the oval boxes) will rarely be as clear-cut as the yes/no options provided. The decision to follow a particular branch will usually be the result of a balance of probabilities. Nonetheless, the flow chart may be a useful decision-making guide for doctors contemplating a

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* The findings of the empirical research, presented in chapter 7, suggest that some doctors will tend *not* to label their proposed action 'deception' if they believe it is morally permissible. This is a weakness of the flow chart. Although one could construct another flow chart to help doctors decide whether their proposed action is deceptive, it will also require them to decide whether the information withheld is 'reasonably expected'. The possibility of biased judgement cannot be entirely eliminated.

potentially deceptive action. For the sake of clarity, the flow chart appears on a new page.

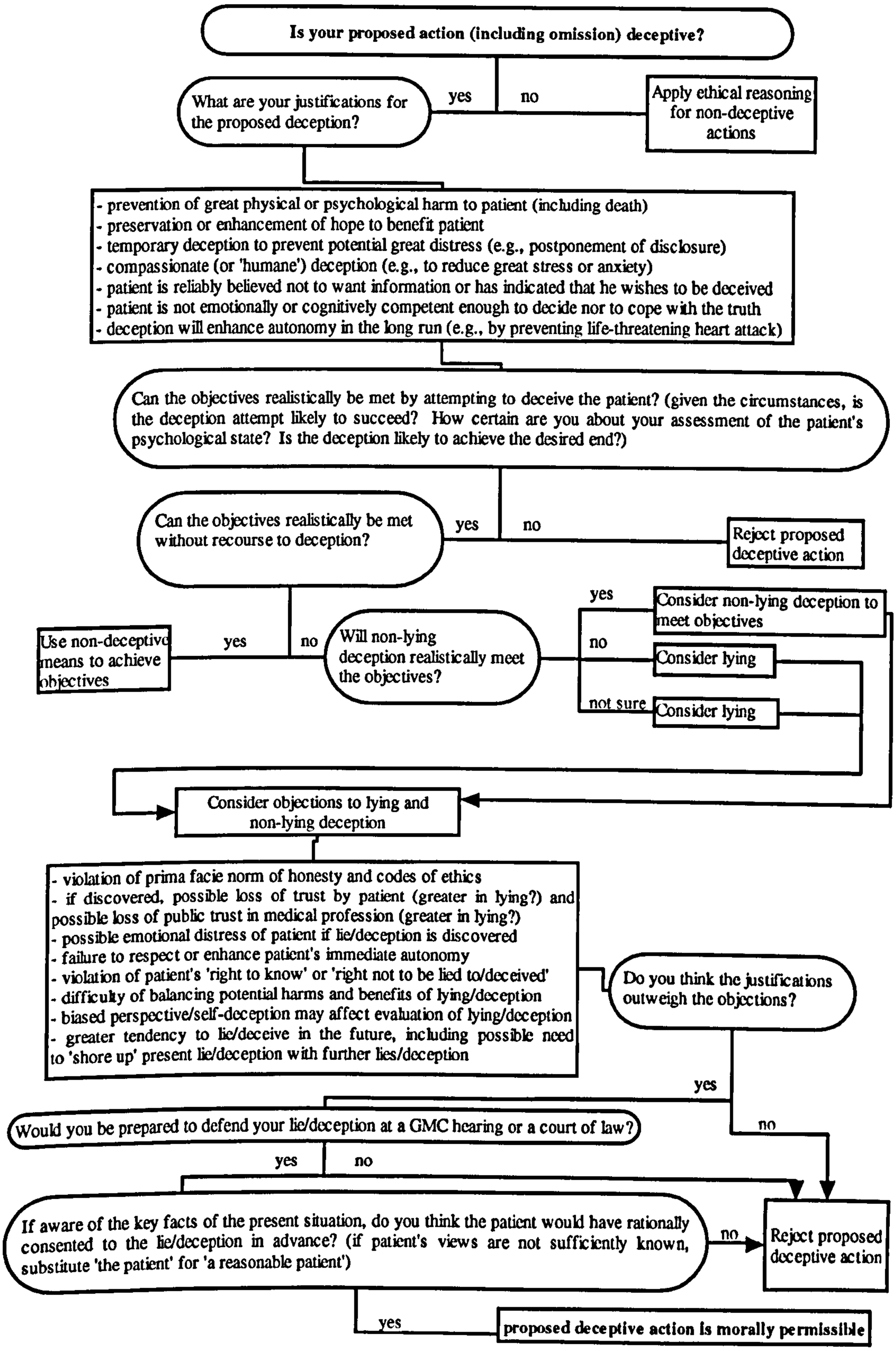


Figure 9: 'deception flow chart' designed to help doctors determine whether a proposed deceptive action is morally permissible

Sharing with colleagues

Another practical suggestion is for doctors to share their practice and philosophy on disclosure to colleagues. One neurologist (neuro2, interview) commented on how the issue of truth-telling and deception was seldom discussed amongst doctors:

> I mean one doesn't tend to discuss these matters with other doctors, it would be quite interesting to do so, particularly in the same specialty because you know the issues are perhaps more finely honed there but one doesn't tend to discuss it.

This sharing of approaches between doctors might encourage self-reflection, foster debate within the profession, and perhaps lead to research on effective practices. Doctors often discuss patient management with colleagues to ensure best practice; perhaps they should also discuss truth-telling practices.

The value of critical reflection

Although I did not select a 'core category' to encapsulate the findings of my empirical research, the best candidate for such a code would have been 'uncertainty'. Griffiths, Green and Tsouroufli have noted that, since research evidence in clinical medicine cannot be directly applied to an individual patient, clinical consultations always contain an element of uncertainty[285](p.511). The present research concludes that uncertainty, of several kinds, is also prevalent in this particular domain of medical ethics. Respondents were uncertain about their own beliefs on truth-telling and deception, about their definitions of lying and deception, about how to balance competing moral goods, about what others wanted to know, about the feasibility or desirability of mutual sharing, and about the prevalence of deception in medicine.

In light of some of these uncertainties and the widely perceived value of discussing and reflecting on truth-telling and deception, stakeholders should be encouraged to reflect on their own preferences, views and reasoning on these issues. As potential patients, the issue of truth-telling in medicine affects us all. Patients, both actual and potential, should surely ponder on their duties *qua* patients and reflect on the difficulty of the doctor's role. Doctors should surely appreciate the realities of patienthood, with its fears and weaknesses but also its strength and diversity. They

should also reflect on their own communicative practices, and ask themselves how truthful or deceptive those are. Such reflection can not only lead to a deeper understanding of ourselves as individuals but may also impact on actual practice. As a result of participating in the research, many patients and members of the public said that they would no longer hesitate to ask questions to doctors and, similarly, many doctors explicitly modified an initial absolutist stance against lying and deception. These are practical changes resulting from a greater consideration of the issues.

4. Interplay between the empirical study and the philosophical/bioethical literature

In chapter 6 (p.128), the diagram below was used to demonstrate the desired relationship between theoretical bioethical debate, empirical research and practical recommendations.

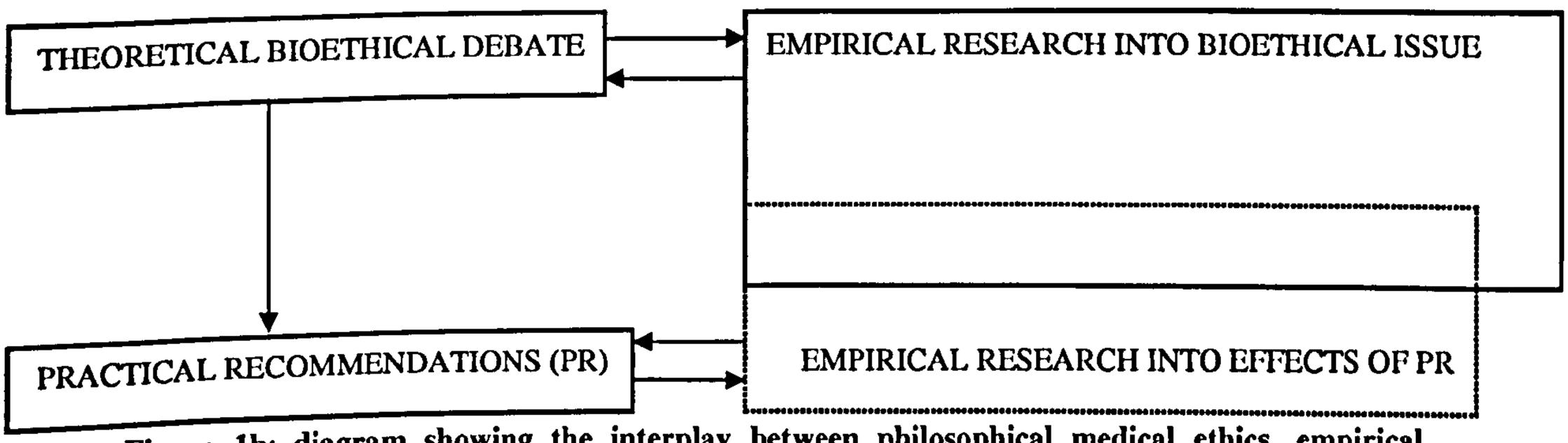


Figure 1b: diagram showing the interplay between philosophical medical ethics, empirical research and practical recommendations

In the same chapter, I argued that although empirical findings should not alone determine right and wrong (a position held by some moral relativists), they can inform bioethical debate in several ways. Firstly, they can support or reject the empirical assumptions built into philosophical arguments. The claim that lying damages trust more than non-lying forms of deception, for example, is thrown into doubt by the present study, which shows that many respondents (and especially patients) consider both categories of deception as morally equivalent in some circumstances. Even with a relatively small, non-random sample, the findings suggest that some people will lose as much trust as a result of non-lying deception as from being lied to. At the very least, the claim needs to be qualified.

Secondly, as the example above demonstrates, empirical work can raise questions pertinent to bioethical analysis through a 'feedback loop'. If patients are more likely to view the two categories of deception as morally on par, why is that so? What distinguishes patients from other groups to explain this difference? And what distinguishes the patients who do consider lying to be morally equivalent to non-lying forms of deception from those who do not? What implications does all this have on the ethics of truth-telling and deception?

Another ethically relevant issue raised by this study is the discrepancy between the assumptions of some doctors regarding the ability of patients to 'read between the lines' and the views of some patients who, in interviews and focus groups, mentioned an inability to be so discerning in consultations. Conversely, it is likely that some doctors fail to respond to the more subtle information-gathering cues of patients, despite believing that they can 'read between the lines' and infer what their patients want to know (p.232-233).

Illnesses and their resulting psychological impact, the dynamics of the doctor-patient relationship, and the peculiar environment of the hospital or GP surgery can all diminish autonomy or prevent the patient from exercising it. This reality -- and its implications for rational choice -- should surely be incorporated (through the feedback loop) into the moral theorizing of bioethicists. The assumption that sick patients are as autonomous as their healthy counterparts can have detrimental effects on their care and, paradoxically, can further reduce the little autonomy they do possess. The often overwhelming circumstances of an adverse disclosure in an unfamiliar environment mean that doctors should make added efforts to find out what the patient autonomously wants.

The feedback loop thus also serves to ground the suggestions of bioethicists on the realities of clinical practice. Since bioethical analysis must be based on relevant facts, empirical investigation is a *sine qua non* of sound and well-informed bioethical assessment. Furthermore, once recommendations have been made and implemented, empirical work can determine whether or not they are desirable in practice. To illustrate with the present research, empirical investigations could allow us to assess the success or failure of the 'ethics history sheet' idea when it is applied in the clinical

context. The findings from the research may then inform the bioethical debate, perhaps showing neglected obstacles to completing the survey, interpreting its contents or implementing the directives.

Finally, if what constitutes patients' 'best interests' is determined in part by patients' own conception of the good, there is clearly some value in ascertaining their views and beliefs on an issue. Although empirical work on a population cannot inform doctors of the desires and values of individual patients, it does make doctors aware of the *range* of values and preferences in a relevant population. This may lead doctors to adopt a more open-minded approach to the sharing of information with patients.

Summary box of the possible contributions of empirical research in bioethics

Empirical research can:

1. verify or refute the empirical assumptions of philosophical claims
2. raise questions relevant to bioethical debate
3. help ensure that the recommendations of bioethicists are workable in practice
4. evaluate the success or otherwise of some bioethical recommendations
5. make doctors aware of the plurality of values held by patients and other groups
6. help to change attitudes based on inadequate empirical information

Implications for empirical medical ethics methodology

Although in depth interviews are probably better suited for the elucidation of moral beliefs and reasoning than other methods, the respondents' notable uncertainty about the ethics of deception makes me less confident about the possibility of capturing the true beliefs and reasoning of respondents. Qualitative interviews are not typically used to delve into people's understanding of abstract ideas but rather to gather accounts of lived experience. Although they did not eliminate the problem, hypothetical scenarios reduced the abstractness of the research by focusing on situated accounts and allowed meaningful comparisons between respondents. Understanding

people's moral reasoning empirically is a major methodological challenge, especially in areas where people are unlikely to have clear ideas about their own position.

A note on methods

Most of the 229 questionnaires received were completed on the World Wide Web. Access was password-protected to prevent 'unsuitable' persons from submitting results. Responses to the online questionnaires were generally easier to read and contained longer answers than their paper equivalent. Indeed, I was surprised by the qualitative richness of the survey data. The completed questionnaires, some containing highly elaborate responses, provided far more than mere quantitative indications of opinion. The survey findings shaped some of the interview questions by pointing to theoretically interesting areas, while the quantitative dimension of the surveys allowed me to detect apparent weights of opinion which were hard to discern from the interviews only. The study thus shows that, with password protection and publicity, questionnaires can be posted and completed on-line with good results and that the method can deliver relatively rich qualitative data. It also demonstrates that the two methods -- questionnaires and interviews -- can complement each other effectively.

Interdisciplinary methodological combinations

A particularly exciting aspect of this thesis has been applying social science methods to a traditional area of philosophical medical ethics.

The project combined three methodologies: 1) an argument-based, philosophical methodology, 2) an empirical approach informed by Grounded Theory approaches and 3) reflective equilibrium. The relationship between these methods is shown in the diagram below:

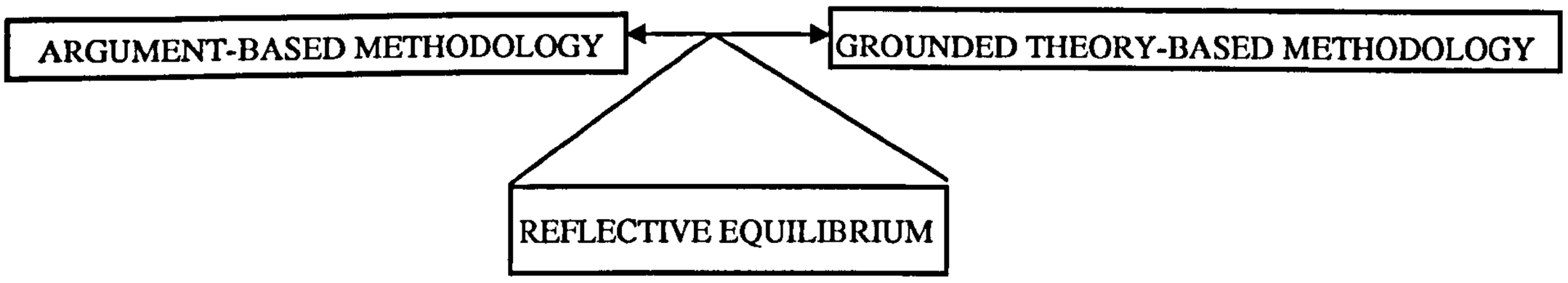


Figure 3: diagram showing the relationship between the three methodologies used in the present research: 1. argument-based, philosophical methodology 2. Grounded Theory-based methodology 3. reflective equilibrium

Reflective equilibrium ensured that each methodology informed and enriched the other. It is a central component in aiming for a more self-aware, critical bioethics which, to quote Hedgecoe, 'tests its theories in the light of empirical experience, and *changes them as a result*'[226](p.137) (his emphasis). Reflective equilibrium bridges theory and practice by constantly testing the two components against each other. In this thesis, reflective equilibrium was used at various stages of the research: to derive empirically testable questions from the philosophical and bioethical literature, to construct the hypothetical scenarios, to unravel the arguments and point out contradictions in the views and reasoning of respondents, and to identify lacunae or false assumptions in the literature on truth-telling and deception. Reflective equilibrium reduces the risk that theoretically oriented bioethicists will recommend what are in theory morally sound but in practice unworkable actions, and that social science oriented researchers will advocate actions which are ethically dubious. It aims for a middle ground which is both ethically and practically satisfactory. This thesis is an attempt to provide a bioethical analysis with a sound philosophical base grounded on the realities of clinical practice.

The lessons learnt from the triangulation of philosophical medical ethics and social science methodologies could be applied beyond the immediate context of this thesis and extrapolated to other areas of bioethical enquiry. Philosophical research can highlight areas of empirical interest which, once elucidated, can enrich the philosophical argumentation through a feedback loop regulated by a process of reflective equilibrium.

The reflective equilibrium methodology is not limited to the realm of scholarship but can also benefit individuals' moral reasoning. In the present research, reflective equilibrium led some respondents to modify their initial views after reflecting on

philosophically informed questions. The scenarios prompted them to reconsider and, in some cases, alter their original beliefs in the face of inconsistent or conflicting intuitions. This demonstrates the educational value of informed discussion on the issues of truth-telling and deception. Indeed, it could be seen as an actualisation of the mutual sharing idea described in chapter 10, not between doctor and patient but between subject and researcher. While I presented various facets of the issues, sharing points of view perhaps unfamiliar to the subjects, they shared their own views and reasoning. Both sides emerged from the experience with a deeper understanding of the issues and, on occasion, of their own position.

Implications for social science research

The empirical research was based on a widely used social science methodology (Grounded Theory) and conventional methods of data collection (semi-structured interviews, questionnaires and focus groups). From a methodological, social science perspective, the approach was not novel. However, the methods were applied in an unusual context. Typically, qualitative research is used to explore people's beliefs and experiences, *not* their reasoning and argumentation, especially about abstract matters such as the definition and moral acceptability of deception.

As I mentioned earlier, the empirical research showed that there may be problems with the use of qualitative methods to explore higher order reasoning. Respondents may find it difficult to articulate complex or imprecise ideas or they may fail to conceptually grasp the question. Even when hypothetical scenarios were used to anchor the issues on concrete situations, respondents occasionally interpreted the situation in unexpected ways, 'filling in' information to determine their moral stance. This reframing of the scenarios complicates the interpretation of the data and highlights the importance of constructing scenarios with minimal room for alternative readings. In my view, these limitations do not invalidate the use of such qualitative approaches to illuminate bioethics. They should, however, encourage the researcher to carefully structure the questions and hypothetical scenarios to reduce, as much as possible, the possibility of confusion and misinterpretation and to enable the expression of higher order reflection. Capturing people's abstract ideas and

arguments is likely to require greater investigative acumen and methodological know-how than gathering people's views on a particular situation or phenomenon.

Reflections and self-critique

Reflecting on the project as a whole, several issues and limitations -- in addition to those already discussed in the methodology chapter (p.171-174) -- are worth noting.

In chapter 6 (p.129-134) and part of the present chapter, I discussed the relevance to bioethical analysis of finding out what people think about moral issues. This remains a controversial issue in the academic literature[286]. My own view is that people's views and reasoning on a particular act or practice do not, in themselves, determine whether or not that act or practice is morally acceptable. Moral justification also requires the support of plausible moral principles and sound arguments regulated by wise judgement (p.138-140). However, good social science research can play a crucial role in helping evaluate the soundness of bioethical arguments containing empirical assumptions (including assumptions about people's views and justifications for those views). It can also raise hitherto neglected issues that may influence bioethical reasoning, help to ensure that practical suggestions deriving from such reasoning are workable in practice (thus satisfying the 'ought implies can' principle), and assess the success or failure of recommendations. In sum, I concluded that empirical social science research and philosophical medical ethics can work in synergy, producing recommendations that are sensitive to context and culture, workable in practice, and ethically sound.

In practice, I swiftly discovered that conducting good empirical research is a challenging task, especially for an inexperienced researcher. Despite the guidance of two academic social scientist supervisors, attendance at courses on qualitative, social science methods, feedback from colleagues in conferences and seminars, and quite extensive reading on the subject, I encountered periods of uncertainty (and anxiety!) in my analysis. In the initial stages, I struggled to make sense of the vast amounts of contradictory data and envied some of the remarkably tidy accounts to be found in social science journals. The learning curve was steep. In my early interviews, I regularly made leading statements and gave overt signs of agreement in my zeal to

establish a good rapport between the interviewee and myself. This may well have 'polluted' the results. Nonetheless, my skills as a social science researcher developed as the study progressed, and I hope that the accounts and interpretations presented in the empirical chapters are firmly grounded on the data.

As the project draws to a close, it is reasonable to ask whether or not the findings of the thesis can be generalised beyond the immediate context of the research. The answer depends on the nature of the findings themselves. Due to the non-probabilistic sampling and the limited number of respondents, any generalisation of the *empirical* data to the population level would be invalid, though such data might suggest avenues for quantitative research. I stated early in the thesis, however, that statistically reliable generalisability was not my aim. My main objective in the empirical research was to gather the views and reasoning of various stakeholders on issues of truth-telling and deception in medicine.

However representative of the general population, the broad numerical indications of consensus and discordance in my study will not help the doctor faced with an individual 'disclosure' decision. Even the most rigorous quantitative statistics do not inform the doctor about the views of the particular patient sitting before him. Conversely, even non-quantitative empirical research such as the present study can provide the doctor with greater knowledge of the range of views and positions that patients can hold. An awareness of such variations can lead to a more open-minded approach to disclosure.

Some findings, derived from the empirical data, can however be generalised. This is true of qualitative work generally. Holm writes 'what we can generalise from qualitative studies is not numbers, frequencies, and numerical correlations. It is explanations, structures, and frameworks'[17](p.218). The arguments, ideas and concepts that make up part of this thesis -- such as the idea of the 'patient as explorer' (p.231) or the various functions of doctors' deception (chapter 9) -- could be applied in other, similar contexts. The conclusions of some of the philosophical arguments could also be generalised beyond the immediate context of the study. The argument that concludes that lying does not *entail* treating someone merely as a means, for

example, is one whose validity can be assessed without reference to a well-defined particular situation.

Aside from the problems of generalising qualitative data, there were also limitations in the research design. Since I did not include a direct question on the moral acceptability of doctors lying to patients, I was unable to ascertain the exact percentage of respondents who adopted an absolutist or non-absolutist position on lying to patients. In retrospect, I should have explicitly asked such a question. In question 21 of the 'doctor' questionnaire ('*Do you consider lying to be morally worse than other forms of deception?*'), I only provided two possible answers: 'yes' and 'no'. To permit a more accurate comparison with the other groups (whose respondents had three options available) I should have added another option: 'both are morally as bad as each other'. I would also have liked to add a scenario based on an example provided by a haematologist who said that he occasionally lied to patients on the phone about the receipt of test results (p.253-254). To avoid disclosing grim news over the phone, he would tell patients that their test results would arrive the next day (despite having already received them) and that an appointment should be made for that date. The inclusion of this scenario would have allowed me to assess more accurately people's views and reasoning on lying in a specific context.

Both the philosophical and empirical components of the thesis address many complex questions on truth-telling and deception. Inevitably, I have focused in more depth on some concepts and questions than others. For example, I examined the concept of deception in detail, but not the concepts of dishonesty, insincerity, trickery, dissimulation or manipulation. Neither did I meticulously dissect the notions of paternalism or dignity. In the empirical research, I explored several issues but still ignored some aspects of doctors' deception, such as the specific ways in which doctors deceive their patients. Clearly, it would have been impossible to examine each relevant concept and question in detail. Untangling the concept of deception alone took me over two years. I therefore focused on concepts and questions which seemed most pertinent to the specific aims of my research.

I may also be accused of an opposite fault: of having tackled too many questions and thus none in sufficiently exhaustive detail. I did not follow up some sub-questions

that arose from my initial questions (for example, the role of nurses in truth-telling dilemmas), although a pure Grounded Theory approach would have required me to investigate these questions iteratively. If this had been a social science thesis, I might have selected just one question and one method (e.g., semi-structured interviews) to examine the question thoroughly. As this is a medical ethics thesis, however, and as the area has been largely unexplored from an empirical angle I took a broader sweep, investigating a range of key issues on the subject and assessing how social science and philosophical medical ethics can complement each other when applied to a substantive issue. As a result of this broad sweep, many questions arose from the research which, although glossed over here, could themselves form the basis of further research.

Further research

Given the problems of generalising some quantitative aspects of the present research, further empirical work would be valuable in permitting accurate generalisations to the population level and elucidating in greater detail differences or similarities within each of the three groups examined here. A quantitative analysis of stakeholders' attitudes to truth-telling and deception in medicine would do much to confirm or refute the tentative suggestions made in the present research.

The constitution of the individual groups could be altered or expanded. More specialties could be included under the category 'doctors', or the scope of the categories could be reduced to focus on a particular age group, sex, or other demographic feature. Do certain ethnic groups, for example, differ in their attitudes to disclosure? Does their reasoning also differ? The focus of further research could shift from inter-group to intra-group comparisons and the implications of any variability on disclosure.

One idea would be to examine the views and reasoning of medical students, junior doctors and more experienced doctors on truth-telling and deception, and then to compare and contrast the findings from each group. This might enable us to assess if and how clinical experience affects people's position on these issues. The research could also dwell on the *formation* of views: what are medical students and junior

doctors taught about the ethics of disclosure, if anything? How do doctors come to acquire the views that they hold? This could form the subject of a further study which may have valuable implications for medical education.

Additional research on truth-telling could focus on nurses, as they sometimes experience an added tension between their own position regarding disclosure and that of the doctor in charge. They also have greater contact with patients and may have a deeper understanding of the repercussions of disclosure on a patient's condition and morale. While I focused on doctors deceiving competent patients, much remains to be done in the area of deception and the incompetent patient. How are the ethics of truth-telling and deception affected by the reduced autonomy of incompetent patients?

This study focused on one side of the doctor-patient relationship: on *doctors* deceiving patients. It would be potentially useful to examine the other side. Do patients deceive their doctors and, if so, when and for what reasons? The current empirical research has already highlighted areas of patient deception, as when cancer patients pretend not to have been told the prognosis by the surgeon in order to gain a second, independent opinion from the oncologist (see chapter 8, p.234). This is a neglected area in medical ethics which deserves more attention as the doctor-patient relationship evolves.

Research, including additional interviews and focus groups with stakeholders and audits in hospital departments and GP surgeries, could be conducted to evaluate the advantages and disadvantages of implementing a questionnaire of the sort that Murtagh and Thorns used in the palliative care setting[129]. This would inform us on how best to pursue the idea of mutual sharing developed in chapter 10.

Finally, there are exciting possibilities in the area of communication research. I only touched upon the deceptive strategies used by doctors and then only through the accounts of respondents themselves. It would be informative to observe actual clinical consultations and examine, first hand, the way information is controlled. Discourse analysis would be well suited for this purpose.

Conclusion

Despite its length, this research project was exploratory, delving into relatively unexplored parts of philosophical medical ethics and using what is so far a rare methodological combination of argument-based philosophical analysis, social science methodology, and reflective equilibrium. It aimed to enrich the debate on the ethics of truth-telling and deception, while demonstrating that bioethics methodology can benefit from the methods and insights of the social sciences and other disciplines.

The present study does not undermine the importance of honesty and truthfulness in the doctor-patient relationship, but it does challenge the seemingly widespread and simplistic notion that these are absolute requirements. Instead, I have proposed a more nuanced approach to these issues, in which the obligations are not absolute but strongly prima facie. Deciding when these obligations can be justifiably overridden is often difficult. Amyarta Sen, in his essay *Capability and Well-being*, warned against ironing out the complexities of an idea: 'if an underlying idea has an essential ambiguity, a precise formulation of that idea must try to *capture* that ambiguity rather than hide or eliminate it'[287](p.33-34) (his emphasis). In this thesis, I have kept the many creases and loose threads to convey the messiness and uncertainty pervading the topic. The ethics of truth-telling and deception in medicine, at least as interpreted within a pluralist framework, illustrate the intricacies of moral choice, often involving the weighing of competing moral goods in the face of uncertainty, shifting circumstances and emotional turmoil.

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Appendix A

Intentional and Unintentional Deception

Although in ordinary parlance, the verb 'to deceive' tends to refer to intentional deception, it is ambiguous. Consider the sentence 'A deceived B'. This could refer to two possibilities:

1. the outcome of A's action, behaviour or appearance was that B was deceived

and/or

2. A intended to mislead B by his action, behaviour or appearance and succeeded in doing so.

In both senses, the outcome is that B is deceived. If B is not misled by A, whether or not A acts intentionally, then A cannot be said to have deceived B. If he did intend to mislead but failed, one could rightly say that A *tried*, unsuccessfully, to deceive B: he did not deceive B but *attempted to deceive* B. To use Gilbert Ryle's terminology, 'to deceive' is a success-verb[288]. If no one is deceived, then no deception has taken place. This is in contrast to lying, which is not a success-verb. I can lie, even though my lie fails to fool my astute 'target'.

Unintentional deception is encompassed by sense 1 but not 2. A could innocently yawn during B's presentation, with no intention to convey any sense of boredom, and still deceive B, who may erroneously infer that A is not enjoying his talk. Following a suggestion by Raanan Gillon (personal communication, July 27, 2005), I shall call this the 'mere outcome' sense of deception. Under the 'mere outcome' sense, A need not even require agency to deceive B. A can be a cabbage which, by virtue of a greenish tinge in the poor light, deceives B, who is convinced that A is a rather pale lettuce.

Sense 2 refers to intentional deception and requires both an intention to deceive and success in doing so. Intent is a necessary but not sufficient condition for deception in

this sense. An examination of ordinary language use appears to support this. If you spot an inept magician palming a card into his pocket, it would be odd to tell a friend that the magician deceived you. You would say that the magician *tried* to deceive you, but failed in his attempt to deceive. No success, no deception. Note that this is not the case with lying. If you were aware that the magician told you a clear lie (for example, "your signed card is now somewhere in the pack" when you know that it is hidden in his pocket), it would still be right to say that the magician lied to you. Lies which do not deceive are still lies.

Appendix B

Assertion

In *Truth and Truthfulness*, Bernard Williams explores the concept of assertion in considerable detail, discerning two notions necessary to understand the nature of assertion: belief and intention[35](p.70). Williams suggests that a speaker who asserts a proposition *p* must intend the hearer to believe that *p*. Thus, to assert "the moon is made of cheese", I must believe that the hearer might come to believe the proposition.

A further condition is that the uttered sentence (S) must correspond to the proposition (P) the speaker is trying to convey. So, if I uttered a random Spanish sentence (S) to someone in order to make them believe that I was Spanish (P), I would not be asserting that I am Spanish. Uttering random Spanish sentences does not mean I am Spanish, although it might indirectly indicate that I am. If, however, I said "Yo soy español" ("I am Spanish"), then I *would* be making an assertion that I am Spanish.

There is some uncertainty regarding the required closeness between what is said (or conveyed) and the intended proposition. One's position on this issue is likely to affect one's definition of lying. In Western culture, is a nod sufficiently close to an affirmation to constitute an assertion? Is writing 'yes' on a piece of paper or making hand signals close enough? If so, then one will probably incorporate these communicative forms in one's definition of lying, as I have in the thesis. If not, one's definition will be narrower, probably restricting lying to verbal communication.

Sincere and insincere assertion

Williams draws a further distinction between sincere and insincere assertion[35](p.73). An agent sincerely asserts *p* if he himself believes that *p*. Williams points out that it would be wrong to define insincere assertion by including the idea of 'pretending to express *p*' since that would capture too much. An ironic statement, such as "what a delightful little dog!" (pointing to an irate, gigantic pit bull terrier) is not an assertion, sincere or insincere. It is not an assertion that the dog is enchanting and diminutive in size (since the speaker does not mean the assertion) nor that the dog was not as

described in the utterance (since this was merely implied). Rather, insincere assertion is defined by Williams as follows:

> An agent insincerely asserts *p* if he intends to misinform the hearer about *p* and/or about the speaker's own beliefs regarding *p*.

An agent who asserts something insincerely thus does not intend to convey the truth about *p* and/or about the truth about his beliefs about *p*. Smith can falsely assert a proposition knowing that Jones will not believe the content of the proposition but that he will believe that he, Smith, believes the proposition.

Acknowledging that it is no more than an 'adequate account', Williams offers the following definition of assertion:

> A utters a sentence "S", where "S" means that P, in doing which either he expresses his belief that P, or he intends the person addressed to take it that he believes that P[35](p.74).

Assumption of speaker conviction

Chisholm and Feehan write that, unlike a statement, an assertion is meant to be taken seriously by the speaker[36](p.151). There is a presumption of epistemic responsibility associated with a speaker's assertion (i.e., that the speaker is committed to the truth of what he says). If Smith asserts *p*, he is not only communicating *p* but also suggesting that his assertion is to be taken seriously. This is one way in which assertions differ from mere statements, which can be made jokingly or ironically. Since an assertion typically indicates that the speaker believes in what is asserted (i.e., the assertum), the hearer typically assumes that the assertum is true. If found to be untrue, the speaker would require a justification for having asserted a false proposition.

Appendix C

Truth-Telling and Benignly Intended Deception in the Doctor-Patient Relationship

Questionnaire for doctors

THIS SURVEY IS ANONYMOUS

- *Please circle (or highlight in bold) the answer that you choose*
- *Each section starts on a new page*
- *Feel free to add any comments to questions on the side of the page or to continue on separate sheets of paper if you wish*

Qu. 1. *Please select your age group*

a. 19 or under
b. 20-29
c. 30-39
d. 40-49
e. 50-59
f. 60-69
g. 70+

Qu. 2. *Please select your gender*

a. male
b. female

Qu. 3. *Please indicate your specialty/subspecialty and position in the space below. E.g., Accident and Emergency, Senior House Officer.*

_____

_____

SECTION 2 – CASE VIGNETTES

This questionnaire was given in a slightly modified form to patients and members of the public.

Please consider the following cases, and respond to the questions below. ***THERE ARE NO RIGHT OR WRONG ANSWERS.*** *Please select the answer that most approximates what <u>you</u> would do, not the answer you consider 'theoretically' correct.*

CASE 1

Susan is an 18-year-old girl wishing to donate a kidney to her father, John, who has a life-threatening kidney disease. Susan and John are very close. During routine blood tests, you discover that John is not, in fact, Susan's *biological* father, although Susan could still donate her kidney to him.

Qu. 4. Would you, as the doctor in charge, be inclined to tell this information to Susan and her father?

a. yes
b. no

Qu. 5. What was/were your main reason(s) for choosing your answer? (please rank your reasons in order of importance, i.e., 1 for most important, 2 for next most important, and so on. Choose as many answers as you wish.)

a. You believe disclosing the information would cause more harm than good
b. You do not wish to destroy the family harmony
c. The patients did not ask for this information
d. The test was not done to discover whether or not the patients were biologically related
e. You feel there is a duty to provide sufficient information for the patient to make an informed decision.
f. You believe both the daughter and father have a 'right to know' the truth
g. Other, please specify (please write answer in space below):

Qu. 6. Do you think NOT providing the information is a form of deception?

a. yes
b. no

i) Please briefly explain and justify your answer to qu. 6 (please write below):

ii) If you were in Susan's position, would you want to be told the truth?

a. yes
b. no

CASE 2

Following a serious car accident, a 26-year-old patient is about to have a life-saving operation which, even if successful, will leave him unable to walk. The patient is a keen climber and has told you that he does not want to live if he cannot walk again. He asks you a few hours before the operation whether he will be able to walk again. You know that his chances are less than one in a hundred.

Qu. 7. Which is your preferred answer?

a. Don't worry, we'll do the best we can
b. I've seen patients with your condition walk again, so let's go for it.
c. Of course you will. Don't worry about it now.
d. I'm afraid there's very little chance you'll walk again, but we'll do our best.

CASE 3

By mistake, you give the wrong dose of medication to an 80-year-old patient. The mistake is minor and the side-effects of the overdose will disappear in a couple of hours, but the patient is, at present, clearly uncomfortable. The patient asks you if her reaction is normal.

Qu. 8. Would you inform the patient of your mistake?

a. yes
b. no

i) What was/were your main reason(s) for choosing your answer? (please rank your reasons in order of importance)

a. You believe disclosing the information would cause more harm than good
b. You do not wish to destroy the trust between you and your patient
c. You are concerned that you may get into legal difficulties or into trouble with hospital authorities
d. You believe the consequences of the mistake are trivial
e. You feel a duty to be honest to the patient about your mistake

f. You believe the patient has a 'right to know' the truth
g. You do not wish to appear incompetent
h. You believe you should apologise to the patient for your mistake
i. Other, please specify (please write below):

ii) If you were the patient, would you have liked to be told about the mistake?

a. yes
b. no

CASE 4

By mistake, you give a wrong and probably lethal dose of medication to an 80-year-old patient suffering from very high blood pressure. Instead of giving the proper dose of 100 milligrams, you misread the vial and gave 1000 milligrams. The patient appears lucid, though clearly very unwell, and asks you if the reaction is normal. You know that it's likely to be a matter of minutes before the patient loses consciousness and dies.

Qu. 9. Do you tell the patient of your mistake?

a. yes
b. no

i) If NO, which of the following would you most likely say:

a. Yes, everything's fine. You should fall asleep soon
b. Don't worry, I'll make sure you're as comfortable as possible
c. The medication I gave should make you feel very sleepy.

ii) In deciding whether or not to inform her of the error, what was/were your main reason(s)? (please rank your reasons in order of importance)

a. You believe disclosing the information would cause more harm than good
b. You do not wish to make her last moments more painful than is absolutely necessary
c. You are concerned that you may get into legal difficulties or into trouble with hospital authorities
d. You have a duty to be honest to the patient about your mistake
e. You believe that, if told, the patient might be enabled to state an important request or to pray
f. You believe you should apologise before the patient dies
g. You would feel guilty if you didn't tell the patient of your mistake
h. You believe the patient has a 'right to know' the truth
i. Other, please specify (please write below):

iii) If you were the patient, would you have liked to be told the truth?

a. yes
b. no

CASE 5

You put your patient on the waiting list for a heart bypass operation. The expected waiting time is 9 months. You know that 40% of patients die while on the waiting list.

Qu. 10. Do you tell your patient this?

a. no
b. yes

i) In this situation, do you consider not telling the patient a form of deception?

a. yes
b. no

ii) Your patient is poor. Do you tell the patient that, if done privately, the operation could be performed very soon?

a. no
b. yes

iii) The patient, worried by the 9-month delay, asks you "but won't I die before my turn?" Are you most likely to:

a. say that many patients on the waiting list *do* get their operation in time
b. say that unfortunately many patients do die on the waiting list but that there is a 60% chance that he/she will get the operation in time.
c. say that some patients die while waiting but that he/she should remain hopeful.
d. Other, please specify (please write below):

If you did *not* choose b) please answer the question below:

iv) The patient then asks you: 'doctor, what percentage of people die while still on the waiting list?'. You are sure that it is roughly 40%. Are you most likely to:

a. tell him this fact

b. repeat that many people *do* get their operation in time.
c. quote a lower percentage
d. claim that you don't know exactly
e. other, please specify (please write below)

v) Briefly explain the reason(s) for your answer to iv) :

CASE 6

Mr Smith is taken to hospital following a heart attack. He is recovering in intensive care and his chances of a full recovery are good. On examination, doctors discover that Mr Smith also has a form of cancer which is quite successfully treatable with modern drugs and radiotherapy. Mr Smith's father died from this type of cancer years before and it is known that Mr Smith has a great fear of the disease. His blood pressure is in poor control and minimizing stress is medically desirable to lower the risks of another heart attack.

Qu.11 Should the doctor, at this time, tell Mr Smith that he has a form of cancer?

a. yes
b. no

i) Briefly explain why you think your answer is justified

ii) Do you think *not* revealing this information is a form of deception?

a. yes
b. no

iii) If Mr Smith asked a question which could only be truthfully answered by telling him that he has this cancer, would the doctor be justified in deceiving his patient?

a. yes
b. no

iv) Would it matter if the doctor deceived the patient by lying or if he deceived him by other means, such as cleverly answering a different question?

a. no, both are the same
b. yes, lying is preferable to using other means of deception
c. yes, deception *without* lying is preferable
d. I don't know

CASE 7

A 26-year-old woman, with two young children, is suffering from a serious form of cancer. She is having radiation therapy, chemotherapy, oxygen and morphine for pain relief several times a day. Although fragile, she is energetic and hopeful. One day, she tells you of her "feeling" that "things aren't going as well as people tell me they are" and of her hopes of that you'll have new "tricks" up your sleeve. She says that she read of a woman dying of leukaemia who wrote stories for her children to remember her by. She continues: "my best friend said I should do the same for my kids, but I don't think I'm *that* far gone, am I, Doctor?" She probably *is* that far gone and is likely to die within a few months. Although in practice discussions with the patient will continue over a period of time, at this stage:

Qu. 12. Are you most likely to:

a. tactfully tell her that she probably is that far gone
b. tell her reassuringly that she isn't that far gone
c. avoid answering the question directly and encourage her to remain hopeful
d. tell her that you don't know for sure but that it would sensible to write the stories because it's a good idea to hope for the best but prepare for the worst
e. other, please specify (please write below):

i) Do you think you answer involved deceiving the patient?

a. yes
b. no

ii) In selecting your answer, what was/were your main reason(s)? (please rank your reasons in order of importance)

a. You didn't want to make the quality of her life worse by making her lose hope
b. You believe she had a better chance of living longer if not told the truth
c. You felt uncomfortable breaking the bad news
d. You believe she had a right to know the truth
e. You felt you had a duty to tell her so that she could make better informed decisions regarding her future.
f. You would feel guilty not giving her this information
g. You believe she would find out later anyway
h. Other, please specify (please write below):

SECTION 3

Qu. 13. How often do you feel deception (e.g., lying, being 'economical with the truth', distorting truth, concealing information, etc.) is used by doctors?

a. often
b. occasionally
c. rarely
d. never
e. I don't know

Qu. 14. How often do you feel deception is used *in your specialty*?

a. often
b. occasionally
c. rarely
d. never

Qu. 14a. When (and if) doctors in your specialty do use deception, how often do you think they do so in order to benefit their patients?

a. often
b. occasionally
c. rarely
d. never
e. I don't know

Qu. 15. Do you believe that it is ever acceptable for doctors to deceive their patients?

a. yes
b. no

Qu. 16. If a new study showed that most doctors lie to their patients when they feel it's in the patients' best interests, do you believe that people would trust doctors less?

a. yes
b. no
c. I don't know

Qu. 17. How often do you use deception with patients?

a. often
b. occasionally
c. rarely
d. never

Qu. 18. If I were a patient, I would find it morally acceptable for my doctor to deceive me if the doctor believed such deception to be in my best interests.

a. yes
b. no
c. I don't know

Qu. 19. More generally, do you think patients would find it morally acceptable for their doctor to deceive them if the doctor believed this was in their best interests?

a. yes
b. no
c. I don't know

Qu. 20. Would you generally feel more, equally, or less comfortable lying to a patient than using other forms of deception (e.g., being economical with the truth, being vague or not answering the question directly)

a. more comfortable lying
b. equally comfortable lying
c. less comfortable lying
d. I don't know

Qu. 21. Do you consider lying to be morally worse than other forms of deception?

a. no
b. yes

i) Please briefly explain your answer to qu. 21:

Qu.21a. Do you think it is *ever* justified to deceive someone in that person's best interests?

a. yes
b. no

Qu.21b. If yes, can you give a non-medical example?

Qu. 22. Have you had any formal instruction in Medical Ethics?

a. no
b. yes

Qu. 23. Has thinking about this questionnaire affected your views on truth-telling and deception in medicine?

a. yes
b. no

i) If YES, please describe briefly:

Qu. 24. Do you think a doctor and his or her patients should know what each other's views are on these issues (i.e., truth-telling and benignly intended deception)?

a. no
b. yes
c. I don't know

Qu. 24a. Please explain your answer

COMMENTS: Any comments you can make on any of the questions above, or on related issues, will be appreciated. Please use this space for your comments.

Would you be prepared to be contacted again for follow-up questions? (any information you provide would still only be used in an anonymous way so that you could not be identified). If so, please provide contact details.

Thank you very much for your time and cooperation

Appendix D

Truth-Telling and Benignly Intended Deception in the Doctor-Patient Relationship

Questionnaire for patients and members of the public

THIS SURVEY IS ANONYMOUS

- *Please circle (or highlight in bold) the answer that you choose*
- *Each section starts on a new page*
- *Feel free to add any comments to questions on the side of the page or to continue on separate sheets of paper if you wish.*

Qu. 1. *Please select your age group*

a. 19 or under
b. 20-29
c. 30-39
d. 40-49
e. 50-59
f. 60-69
g. 70+

Qu. 2. *Please indicate your gender*

a. male
b. female

Qu. 3. *Please select the option closest to your educational level*

a. not obtained any examination qualifications
b. obtained a basic secondary school qualification (e.g., GCSEs/O-levels)
c. obtained an advanced level qualification (e.g., AS/A-levels, GNVQs)
d. obtained a University degree
e. obtained a postgraduate degree

Qu. 4 *What best describes your household's income?*

a. less than £10 000
b. £10 001 to £20 000

c. £20 001 to £30 000
d. £30 001 to £50 000
e. more than £50 000

Qu. 5 *If you are a patient, what is the nature of your illness?*

a. Skin problem
b. Cancer
c. Heart problem
d. Psychological disorder
e. Other, please describe briefly

_____

_____

Qu. 6 *How serious would you consider your illness?*

a. Harmless
b. Mild
c. Moderate
d. Severe
e. Very Severe

SECTION 2 – CASE VIGNETTES

Please consider the following cases, and respond to the questions below. ***THERE ARE NO RIGHT OR WRONG ANSWERS.*** *We just want to know what you think doctors should do and why you think so.*

CASE 1

Susan is an 18-year-old girl wishing to donate a kidney to her father, John, who has a life-threatening kidney disease. Susan and John are very close. During routine blood tests, the doctors discover that John is not, in fact, Susan's *biological* father, although Susan could still donate her kidney to him.

Qu. 7. Should the doctor in charge tell this information to Susan and her father?

a. yes
b. no

Qu. 8. What was/were your main reason(s) for choosing your answer? (please rank your reasons in order of importance, i.e., 1 for most important, 2 for next most important, and so on. Choose as many answers as you wish.)

a. You believe telling the information would cause more harm than good
b. Telling the information might destroy the family harmony
c. The patients did not ask for this information
d. The test was not done to discover whether or not the patients were biologically related.
e. You feel the doctor has a duty to provide enough information for the patient to make an informed decision.
f. You believe both the daughter and father have a 'right to know' the truth
g. Other, please specify (please write answer in space below):

Qu. 9. Do you think NOT giving the information is a form of deception?

a. yes
b. no

i) Please briefly explain and justify your answer to qu. 9 (please write below):

ii) If you were in Susan's position, would you want to be told the truth?

a. yes
b. no

CASE 2

Following a serious car accident, a 26-year-old patient is about to have a life-saving operation which, even if successful, will leave him unable to walk. The patient is a keen climber and has told the doctor that he does not want to live if he cannot walk again. He asks the doctor a few hours before the operation whether he will be able to walk again. The doctor knows that his chances are less than one in a hundred.

Qu. 10. Which answer should the doctor give?

a. Don't worry, we'll do the best we can
b. I've seen patients with your condition walk again, so let's go for it.
c. Of course you will. Don't worry about it now.
d. I'm afraid there's very little chance you'll walk again, but we'll do our best.

CASE 3

The doctor, by mistake, gives the wrong dose of medication to an 80-year-old patient. The mistake is minor and the side-effects of the overdose will disappear in a couple of hours, but the patient is, at present, clearly uncomfortable. The patient asks the doctor if her reaction is normal.

Qu. 11. Should the doctor inform the patient of the mistake?

a. yes
b. no

i) What was/were your main reason(s) for choosing your answer (please rank your reasons in order of importance)

a. You believe disclosing the information would cause more harm than good
b. The doctor should not wish to destroy the trust between himself/herself and the patient
c. The doctor may get into legal difficulties or into trouble with the hospital authorities
d. You believe the consequences of the mistake are trivial
e. You feel the doctor has a duty to be honest to the patient about his/her mistake
f. You believe the patient has a 'right to know' the truth
g. You believe the doctor should apologise to the patient for his/her mistake
h. Other, please specify (please write below):

ii) If you were the patient, would you have liked to be told about the mistake?

a. yes
b. no

CASE 4

The doctor, by mistake, gives a wrong and probably lethal dose of medication to an 80-year-old patient suffering from very high blood pressure. Instead of giving the proper dose of 100 milligrams, the doctor misread the vial and gave 1000 milligrams. The patient appears lucid, though clearly very unwell, and asks the doctor if the reaction is normal. The doctor knows that it's likely to be a matter of minutes before the patient loses consciousness and dies.

Qu. 12. Should the doctor inform the patient of his/her mistake?

a. yes
b. no

i) If NO, which of the following should the doctor say:

a. Yes, everything's fine. You should fall asleep soon
b. Don't worry, I'll make sure you're as comfortable as possible
c. The medicine I gave you should make you feel very sleepy

ii) In deciding whether or not the doctor should inform the patient of the error, what was/were your main reason(s)? (please rank your reasons in order of importance)

a. You believe disclosing the information would cause more harm than good
b. The doctor should not wish to make the patient's last moments more painful than is absolutely necessary
c. The doctor may get into legal difficulties or into trouble with the hospital authorities
d. You feel the doctor has a duty to be honest to the patient about his/her mistake
e. You believe that, if told, the patient might be enabled to state an important request or to pray
f. You feel the doctor should apologise to the patient before the patient dies
g. You believe the patient has a 'right to know' the truth
h. Other, please specify (please write below):

iii) If you were the patient, would you have liked to be told the truth?

a. yes
b. no

CASE 5

The doctor puts the patient on the waiting list for a heart transplant. The expected waiting time is 9 months. The doctor knows that 40% of patients die while on the waiting list.

Qu. 13. Should the doctor tell the patient this?

a. no
b. yes

i) In this situation, do you consider not telling the patient a form of deception?

a. yes
b. no

ii) The patient is poor. Should the doctor tell the patient that, if done privately, the operation could be done very soon?

a. no
b. yes

iii) The patient, worried by the 9-month delay, asks the doctor "but won't I die before my turn?" Should the doctor:

a. say that many patients on the waiting list *do* get their operation in time
b. say that unfortunately many patients do die on the waiting list but that there is a 60% chance that he/she will get the operation in time.
c. say that some patients die while waiting but that he/she should remain hopeful.
d. Other, please specify (please write below):

If you did *not* choose b) please answer the question below:

iv) The patient then asks: 'doctor, what percentage of people die while still on the waiting list?'. The doctor is sure that it is roughly 40%. Should the doctor:

a. tell the patient this fact
b. repeat that many people *do* get their operation in time.
c. quote a lower percentage
d. claim that he/she doesn't know exactly
e. other, please specify (please write below)

v) Briefly explain the reason(s) for your answer to iv)

CASE 6

Mr Smith is taken to hospital following a heart attack. He is recovering in intensive care and his chances of a full recovery are good. On examination, doctors discover that Mr Smith has a form of cancer which is quite successfully treatable with modern drugs and radiotherapy. Mr Smith's father died from this type of cancer years before and it is known that Mr Smith has a great fear of the disease. His blood pressure is in poor control and minimizing stress is medically desirable to lower the risks of another heart attack.

Qu.14. Should the doctor, at this time, tell Mr Smith that he has a form of cancer?

a. yes
b. no

i) Briefly explain why you think your answer is justified

ii) Do you think *not* revealing this information is a form of deception?

a. yes
b. no

iii) If Mr Smith asked a question which could only be truthfully answered by telling him that he has this cancer, would the doctor be justified in deceiving his patient?

a. yes
b. no

iv) Would it matter if the doctor deceived the patient by lying or if he deceived him by other means, such as cleverly answering a different question?

a. no, both are the same
b. yes, lying is preferable to using other means of deception
c. yes, deception *without* lying is preferable
d. I don't know

CASE 7

A 26-year-old woman, with two young children, is suffering from a serious form of cancer. She is having radiation therapy, chemotherapy, oxygen and morphine for pain relief several times a day. Although fragile, she is energetic and hopeful. One day, she tells the doctor of her "feeling" that "things aren't going as well as people tell me they are" and of her hopes that he [the doctor] will have new "tricks" up his sleeve.

She says that she read of a woman dying of leukaemia who wrote stories for her children to remember her by. She continues: "my best friend said I should do the same for my kids, but I don't think I'm *that* far gone, am I, Doctor?" She probably *is* that far gone and is likely to die within a few months. Although in practice discussions between the doctor and patient will continue over a period of time, at this stage:

Qu. 15. Should the doctor:

a. tactfully tell her that she probably is that far gone
b. Tell her reassuringly that she isn't that far gone
c. avoid answering the question directly and encourage her to remain hopeful
d. tell her that he/she doesn't know for sure but that it would be sensible to write the stories because it's a good idea to hope for the best but prepare for the worst
e. other, please specify (please write below):

i) Do you think your answer involved deceiving the patient?

a. yes
b. no

ii) In selecting your answer, what was/were your main reason(s) (please rank your reasons in order of importance)

a. The doctor should not make the quality of her life worse by making her lose hope
b. You believe she had a better chance of living longer if not told the truth
c. You believe she had a right to know the truth
d. You felt the doctor had a duty to tell her so that she could make better informed decisions about her future.
e. You believe she would find out later anyway
f. Other, please write below:

SECTION 3

Qu. 16. How often do you think deception (e.g., lying, being 'economical with the truth', distorting truth, concealing information, etc.) is used by doctors?

a. often
b. occasionally
c. rarely
d. never
e. I don't know

Qu. 16a. How often do you think doctors use deception in order to benefit their patients?

a. often
b. occasionally
c. rarely
d. never
e. I don't know

Qu. 17. Do you believe that it is ever acceptable for doctors to deceive their patients?

a. yes
b. no

Qu. 18. Do you think that most patients would find it morally acceptable for their doctor to deceive them if the doctor believed such deception was in their best interests?

a. yes
b. no
c. I don't know

Qu. 19. As a patient, would you find it morally acceptable for your doctor to deceive you if he/she believed such deception was in your best interests?

a. yes
b. no
d. I don't know

Qu. 20. Do you think a GP or hospital doctor has ever deceived you, a relative or a friend?

a. yes
b. no
c. I don't know

i) If YES, please describe (please write below):

Qu. 21. Which do you consider worse: a doctor who withholds important information from you or a doctor who lies to you about important information?

a. the doctor withholding information is worse than the doctor lying
b. the doctor lying is worse than the doctor withholding information
c. both are equally bad

i) Please briefly explain your answer to qu. 21:

Qu. 21a. Do you think it is *ever* acceptable to deceive someone in that person's best interests?

a. yes
b. no

Qu. 21b. If yes, can you give a non-medical example?

Qu. 22. Has thinking about this questionnaire affected your views on truth-telling and deception in medicine?

a. yes
b. no

i) If YES, please describe briefly:

Qu. 23. Do you think a doctor and his or her patients should know what each other's views are on these issues (i.e., truth-telling and benignly intended deception)?

a. no
b. yes
c. I don't know

Qu.23a. Please explain your answer

COMMENTS: Any comments you can make on any of the questions above, or on related issues, will be appreciated. Please use this space for your comments.

Would you be prepared to be contacted again for follow-up questions? (any information you provide would still only be used in an anonymized way so that you could not be identified). If so, please provide contact details.

Thank you very much for your time and cooperation

Appendix E

Summary of results for doctors' questionnaire (n=85)

Qu. 1. *Please select your age group*

a.	19 or under	0	0%*
b.	20-29	6	7%
c.	30-39	27	32%
d.	**40-49**	**28**	**33%**
e.	50-59	19	22%
f.	60-69	4	5%
g.	70+	1	1%

Qu. 2. *Please indicate your gender*

a.	**male**	**52**	**61%**
b.	female	33	39%

Qu. 3. *Please indicate specialty*

33 GPs, 19 palliative care doctors, 10 oncologists, 5 dermatologists, 5 anaesthetists, 13 'other specialties'.

SECTION 2 – CASE VIGNETTES

CASE 1

Susan is an 18-year-old girl wishing to donate a kidney to her father, John, who has a life-threatening kidney disease. Susan and John are very close. During routine blood tests, the doctors discover that John is not, in fact, Susan's *biological* father, although Susan could still donate her kidney to him.

Qu. 4. Should the doctor in charge tell this information to Susan and her father?

a.	yes	30	36%
b.	**no**	**53**	**63%**

1 blank, 1 'not necessarily'

---

* Percentages are rounded to the nearest whole number. Consequently, the total may not equal 100. Answers left blank were not considered valid and thus were not included in calculating percentages. The same applies for appendices F and G.

Qu. 5. What was/were your main reason(s) for choosing your answer? (please rank your reasons in order of importance, i.e., 1 for most important, 2 for next most important, and so on. Choose as many answers as you wish.)

a. **You believe telling the information would cause more harm than good**
b. Telling the information might destroy the family harmony
c. The patients did not ask for this information
d. **The test was not done to discover whether or not the patients were biologically related.**
e. You feel the doctor has a duty to provide enough information for the patient to make an informed decision.
f. You believe both the daughter and father have a 'right to know' the truth
g. Other, please specify (please write answer in space below):

Option	Pref. 1	P2	P3	P4	P5	P6	P7
A	**22**	**9**	**10**	**4**	**3**	**1**	**1**
B	1	13	9	9	3	5	0
C	10	17	9	9	1	0	2
D	**21**	**10**	**15**	**6**	**1**	**0**	**1**
E	19	11	3	1	3	2	0
F	10	9	4	1	3	3	2
G	5	4	2	0	2	0	1

Qu. 6. Do you think NOT giving the information is a form of deception?

a. yes 43 51%
b. no 41 49%

1 blank

ii) If you were in Susan's position, would you want to be told the truth?

a. yes 31 38%
b. no 49 60%

2 blanks, 2 'don't know', 1 'depends'

CASE 2

Following a serious car accident, a 26-year-old patient is about to have a life-saving operation which, even if successful, will leave him unable to walk. The patient is a keen climber and has told the doctor that he does not want to live if he cannot walk again. He asks the doctor a few hours before the operation whether he will be able to walk again. The doctor knows that his chances are less than one in a hundred.

Qu. 7. Which answer should the doctor give?

a. Don't worry, we'll do the best we can 5 6%
b. I've seen patients with your condition walk again, so let's go for it 9 11%
c. Of course you will. Don't worry about it now 0 0%
d. I'm afraid there's very little chance you'll walk again, but we'll do our best 71 84%

CASE 3

The doctor, by mistake, gives the wrong dose of medication to an 80-year-old patient. The mistake is minor and the side-effects of the overdose will disappear in a couple of hours, but the patient is, at present, clearly uncomfortable. The patient asks the doctor if her reaction is normal.

Qu. 8. Should the doctor inform the patient of the mistake?

a. yes 79 93%
b. no 6 7%

i) What was/were your main reason(s) for choosing your answer (please rank your reasons in order of importance)

h. You believe disclosing the information would cause more harm than good
i. The doctor should not wish to destroy the trust between himself/herself and the patient
j. The doctor may get into legal difficulties or into trouble with the hospital authorities
k. You believe the consequences of the mistake are trivial
l. You feel the doctor has a duty to be honest to the patient about his/her mistake
m. You believe the patient has a 'right to know' the truth
n. You do not wish to appear incompetent
o. You believe the doctor should apologise to the patient for his/her mistake
p. Other, please specify (please write below):

Option	Pref. 1	P2	P3	P4	P5	P6	P7	P8	P9
H	4	3	1	0	0	1	3	1	3
I	8	7	12	9	1	0	2	0	0
J	0	1	4	4	3	2	1	2	2
K	3	5	6	0	4	2	1	0	0
L	**50**	**21**	**2**	**3**	**1**	**0**	**0**	**0**	**0**
M	12	16	16	6	0	0	1	0	0
N	0	1	2	5	2	1	1	2	0
O	16	22	18	4	2	3	0	1	0
P	1	2	0	1	0	0	0	0	0

ii) If you were the patient, would you have liked to be told about the mistake?

a.	**yes**	**76**	**92%**
b.	no	7	8%

2 blanks

CASE 4

The doctor, by mistake, gives a wrong and probably lethal dose of medication to an 80-year-old patient suffering from very high blood pressure. Instead of giving the proper dose of 100 milligrams, the doctor misread the vial and gave 1000 milligrams. The patient appears lucid, though clearly very unwell, and asks the doctor if the reaction is normal. The doctor knows that it's likely to be a matter of minutes before the patient loses consciousness and dies.

Qu. 9. Should the doctor inform the patient of his/her mistake?

a.	**yes**	**47**	**57%**
b.	no	36	43%

2 blanks

i) If NO, which of the following should the doctor say:

a.	Yes, everything's fine. You should fall asleep soon	0
b.	Don't worry, I'll make sure you're as comfortable as possible	14
c.	**The medicine I gave you should make you feel very sleepy**	**19**

ii) In deciding whether or not the doctor should inform the patient of the error, what was/were your main reason(s)? (please rank your reasons in order of importance)

a. You believe disclosing the information would cause more harm than good
b. The doctor should not wish to make the patient's last moments more painful than is absolutely necessary
c. The doctor may get into legal difficulties or into trouble with the hospital authorities
d. You feel the doctor has a duty to be honest to the patient about his/her mistake
e. You believe that, if told, the patient might be enabled to state an important request or to pray
f. You feel the doctor should apologise to the patient before the patient dies
g. You would feel guilty if you didn't tell the patient of your mistake
h. You believe the patient has a 'right to know' the truth
i. Other, please specify (please write below):

Option	Pref. 1	P2	P3	P4	P5	P6	P7	P8	P9
A	6	17	2	0	0	0	2	1	0
B	26	6	1	1	1	2	0	0	0
C	1	0	4	1	0	1	1	4	1
D	28	10	3	2	0	3	1	0	0

E	6	17	7	4	3	0	0	1	0
F	2	4	19	6	4	2	0	0	0
G	6	5	5	9	5	1	2	0	0
H	8	6	8	9	5	0	1	0	0
I	7	3	4	1	0	0	0	0	0

iii) If you were the patient, would you have liked to be told the truth?

a. yes 41 51%
b. no 36 44%

4 blanks, 3 'not sure', 1 'depends'

CASE 5

The doctor puts the patient on the waiting list for a heart transplant. The expected waiting time is 9 months. The doctor knows that 40% of patients die while on the waiting list.

Qu. 10. Should the doctor tell the patient this?

a. no 35 41%
b. yes 50 59%

i) In this situation, do you consider not telling the patient a form of deception?

a. yes 55 68%
b. no 26 32%

4 blanks

ii) The patient is poor. Should the doctor tell the patient that, if done privately, the operation could be done very soon?

a. no 48 58%
b. yes 35 42%

2 blanks

iii) The patient, worried by the 9-month delay, asks the doctor "but won't I die before my turn?" Should the doctor:

a. say that many patients on the waiting list *do* get their operation in time 21 25%
b. say that unfortunately many patients do die on the waiting list but that there is a 60% chance that he/she will get the operation in time. 26 31%
c. say that some patients die while waiting but that he/she should remain hopeful. 35 41%

d. Other, please specify (please write below) 3 3%

If you did *not* choose b) please answer the question below:

iv) The patient then asks: 'doctor, what percentage of people die while still on the waiting list?'. The doctor is sure that it is roughly 40%. Should the doctor:

a. tell the patient this fact	**55**
b. repeat that many people *do* get their operation in time.	5
c. quote a lower percentage	0
d. claim that he/she doesn't know exactly	3
e. other, please specify (please write below)	2

CASE 6

Mr Smith is taken to hospital following a heart attack. He is recovering in intensive care and his chances of a full recovery are good. On examination, doctors discover that Mr Smith has a form of cancer which is quite successfully treatable with modern drugs and radiotherapy. Mr Smith's father died from this type of cancer years before and it is known that Mr Smith has a great fear of the disease. His blood pressure is in poor control and minimizing stress is medically desirable to lower the risks of another heart attack.

Qu.11. Should the doctor, at this time, tell Mr Smith that he has a form of cancer?

a. yes	24	29%
b. no	**60**	**71%**

1 blank

ii) Do you think *not* revealing this information is a form of deception?

a. yes	31	37%
b. no	**53**	**63%**

1 blank

iii) If Mr Smith asked a question which could only be truthfully answered by telling him that he has this cancer, would the doctor be justified in deceiving his patient?

a. yes	9	11%
b. no	**76**	**89%**

iv) Would it matter if the doctor deceived the patient by lying or if he deceived him by other means, such as cleverly answering a different question?

a.	**no, both are the same**	**44**	**54%**
b.	yes, lying is preferable to using other means of deception	0	0%
c.	yes, deception *without* lying is preferable	18	22%
d.	I don't know	20	24%

3 blanks

CASE 7

A 26-year-old woman, with two young children, is suffering from a serious form of cancer. She is having radiation therapy, chemotherapy, oxygen and morphine for pain relief several times a day. Although fragile, she is energetic and hopeful. One day, she tells the doctor of her "feeling" that "things aren't going as well as people tell me they are" and of her hopes that he [the doctor] will have new "tricks" up his sleeve. She says that she read of a woman dying of leukaemia who wrote stories for her children to remember her by. She continues: "my best friend said I should do the same for my kids, but I don't think I'm *that* far gone, am I, Doctor?" She probably *is* that far gone and is likely to die within a few months. Although in practice discussions between the doctor and patient will continue over a period of time, at this stage:

Qu. 12. Should the doctor:

a.	tactfully tell her that she probably is that far gone	38	45%
b.	Tell her reassuringly that she isn't that far gone	0	0%
c.	avoid answering the question directly and encourage her to remain hopeful	0	0%
d.	**tell her that he/she doesn't know for sure but that it would be sensible to write the stories because it's a good idea to hope for the best but prepare for the worst**	**42**	**49%**
e.	other, please specify (please write below):	5	6%

i) Do you think your answer involved deceiving the patient?

a.	yes	3 (all three chose option d. above)	4%
b.	**no**	**79**	**96%**

3 blanks

ii) In selecting your answer, what was/were your main reason(s) (please rank your reasons in order of importance)

a. The doctor should not make the quality of her life worse by making her lose hope
b. You believe she had a better chance of living longer *if not told the truth*
c. You felt uncomfortable breaking the bad news
d. You believe she had a right to know the truth

e. **You felt the doctor had a duty to tell her so that she could make better informed decisions about her future**
f. You would feel guilty not giving her this information
g. You believe she would find out later anyway
h. Other, please write below:

Option	Pref. 1	P2	P3	P4	P5	P6	P7	P8
A	12	9	4	2	0	1	1	0
B	0	3	0	2	4	2	2	0
C	2	4	1	1	2	0	0	0
D	18	28	2	3	0	0	0	0
E	**48**	**15**	**4**	**2**	**1**	**0**	**0**	**0**
F	3	1	10	2	0	0	2	0
G	3	5	14	4	1	1	0	2
H	5	3	2	1	0	0	0	0

SECTION 3

Qu. 13. How often do you think deception (e.g., lying, being 'economical with the truth', distorting truth, concealing information, etc.) is used by doctors?

a.	Often	38	45%
b.	**Occasionally**	**39**	**46%**
c.	Rarely	5	6%
d.	Never	0	0%
e.	I don't know	3	4%

Qu. 14. How often do you feel deception is used *in your specialty*?

a.	Often	10	12%
b.	**Occasionally**	**47**	**58%**
c.	Rarely	21	26%
d.	Never	3	4%
e.	I don't know	0	0%

4 blanks

Qu. 14a. When (and if) doctors in your specialty do use deception, how often do you think they do so in order to benefit their patients?

a.	**Often**	**50**	**60%**
b.	Occasionally	17	20%
c.	Rarely	8	10%
d.	Never	1	1%
e.	I don't know	7	8%

1 blank and 1 'n/a'

Qu. 15. Do you believe that it is ever acceptable for doctors to deceive their patients?

a.	**yes**	**59**	**70%**
b.	no	25	30%

1 blank

Qu. 16. If a new study showed that most doctors lie to their patients when they feel it's in the patients' best interests, do you believe that people would trust doctors less?

a.	**yes**	**50**	**60%**
b.	no	16	19%
c.	I don't know	18	21%

1 blank

Qu. 17. How often do you use deception with patients?

a.	Often	1	1%
b.	Occasionally	21	25%
c.	**Rarely**	**49**	**59%**
d.	Never	12	14%

2 blanks

Qu. 18. If I were a patient, I would find it morally acceptable for my doctor to deceive me if the doctor believed such deception to be in my best interests.

a.	yes	28	33%
b.	**no**	**42**	**49%**
c.	I don't know	15	18%

Qu. 19. More generally, do you think that most patients would find it morally acceptable for their doctor to deceive them if the doctor believed this was in their best interests?

a.	yes	27	33%
b.	**no**	**35**	**42%**
c.	I don't know	21	25%

2 blanks

Qu. 20. Would you generally feel more, equally, or less comfortable lying to a patient than using other forms of deception (e.g., being economical with the truth, being vague or not answering the question directly)

a.	more comfortable lying	1	1%
b.	equally comfortable lying	3	4%
c.	**less comfortable lying**	**71**	**87%**

d.	I don't know	7	9%

3 blanks.

Qu. 21. Do you consider lying to be morally worse than other forms of deception?

a.	**yes**	**64**	**77%**
b.	no	19	23%

2 blanks

Qu. 21a. Do you think it is *ever* acceptable to deceive someone in that person's best interests?

a.	**yes**	68	82%
b.	no	14	17%

2 blanks, 1 'not sure'

Qu. 22. Have you had any formal instruction in Medical Ethics?

a.	**no**	**46**	**55%**
b.	yes	38	45%

1 blank

Qu. 23. Has thinking about this questionnaire affected your views on truth-telling and deception in medicine?

a.	yes	38	45%
b.	**no**	**47**	**55%**

Qu. 24. Do you think a doctor and his or her patients should know what each other's views are on these issues (i.e., truth-telling and benignly intended deception)?

a.	no	9	11%
b.	**yes**	**56**	**67%**
c.	I don't know	18	22%

2 blanks

Appendix F

Summary of results for patient questionnaire (n=88)

Qu. 1. *Please select your age group*

a.	19 or under	0	0%
b.	20-29	6	7%
c.	30-39	22	25%
d.	**40-49**	**25**	**28%**
e.	50-59	21	24%
f.	60-69	10	11%
g.	70+	4	5%

Qu. 2. *Please indicate your gender*

a.	male	21	24%
b.	**female**	**67**	**76%**

Qu. 3. *Please select the option closest to your educational level*

a.	not obtained any examination qualifications	4	5%
b.	obtained a basic secondary school qualification (e.g., GCSEs/O-levels)	12	14%
c.	obtained an advanced level qualification (e.g., AS/A-levels, GNVQs)	24	28%
d.	**obtained a University degree**	**25**	**29%**
e.	obtained a postgraduate degree	22	25%

1 blank

Qu. 4 *What best describes your household's income?*

a.	less than £10 000	10	12%
b.	£10 001 to £20 000	14	16%
c.	£20 001 to £30 000	18	21%
d.	**£30 001 to £50 000**	**22**	**26%**
e.	more than £50 000	21	25%

3 blanks

Qu. 5 *If you are a patient, what is the nature of your illness?*

a.	Skin problem	4	5%
b.	Cancer	7	8%
c.	Heart problem	2	2%
d.	Psychological disorder	0	0%
e.	**Other, please describe briefly**	**75**	**85%**

Other diseases included pancreatitis, HIV/AIDS, hernia, MRSA, *haemophilia*, hepatitis, endocrine disorder, hypothyroidism, diabetes.

Qu. 6 *How serious would you consider your illness?*

a.	Harmless	3	3%
b.	Mild	8	9%
c.	**Moderate**	**31**	**35%**
d.	Severe	28	32%
e.	Very Severe	18	20%

SECTION 2 – CASE VIGNETTES

CASE 1

Susan is an 18-year-old girl wishing to donate a kidney to her father, John, who has a life-threatening kidney disease. Susan and John are very close. During routine blood tests, the doctors discover that John is not, in fact, Susan's *biological* father, although Susan could still donate her kidney to him.

Qu. 7. Should the doctor in charge tell this information to Susan and her father?

a.	yes	27	31%
b.	**no**	**60**	**69%**

1 blank

Qu. 8. What was/were your main reason(s) for choosing your answer? (please rank your reasons in order of importance, i.e., 1 for most important, 2 for next most important, and so on. Choose as many answers as you wish.)

a. You believe telling the information would cause more harm than good
b. Telling the information might destroy the family harmony
c. The patients did not ask for this information
d. The test was not done to discover whether or not the patients were biologically related.
e. You feel the doctor has a duty to provide enough information for the patient to make an informed decision.
f. You *believe* both the daughter and father have a 'right to know' the truth
g. Other, please specify (*please write answer* in space below):

Option	Pref. 1	P2	P3	P4	P5	P6	P7
A	15	13	8	3	5	3	1
B	8	12	10	5	2	2	2
C	11	15	10	12	2	2	1
D	**29**	**10**	**14**	**4**	**2**	**1**	**3**

E	15	10	2	3	4	4	0
F	14	8	0	2	3	5	6
G	6	3	3	2	0	0	1

Qu. 9. Do you think NOT giving the information is a form of deception?

a. yes 39 44%
b. no 49 56%

ii) If you were in Susan's position, would you want to be told the truth?

a. yes 43 49%
b. no 44 51%

1 blank

CASE 2

Following a serious car accident, a 26-year-old patient is about to have a life-saving operation which, even if successful, will leave him unable to walk. The patient is a keen climber and has told the doctor that he does not want to live if he cannot walk again. He asks the doctor a few hours before the operation whether he will be able to walk again. The doctor knows that his chances are less than one in a hundred.

Qu. 10. Which answer should the doctor give?

a. Don't worry, we'll do the best we can 8 9%
b. I've seen patients with your condition walk again, so let's go for it 12 14%
c. Of course you will. Don't worry about it now 0 0%
d. I'm afraid there's very little chance you'll walk again, but we'll do our best 68 77%

CASE 3

The doctor, by mistake, gives the wrong dose of medication to an 80-year-old patient. The mistake is minor and the side-effects of the overdose will disappear in a couple of hours, but the patient is, at present, clearly uncomfortable. The patient asks the doctor if her reaction is normal.

Qu. 11. Should the doctor inform the patient of the mistake?

a. yes 73 84%
b. no 14 16%

1 blank

i) What was/were your main reason(s) for choosing your answer (please rank your reasons in order of importance)

h. You believe disclosing the information would cause more harm than good
i. The doctor should not wish to destroy the trust between himself/herself and the patient
j. The doctor may get into legal difficulties or into trouble with the hospital authorities
k. You believe the consequences of the mistake are trivial
l. You feel the doctor has a duty to be honest to the patient about *his/her* mistake
m. You believe the patient has a 'right to know' the truth
n. You believe the doctor should apologise to the patient for his/her mistake
o. Other, please specify (please write below):

Option	Pref. 1	P2	P3	P4	P5	P6	P7	P8
H	5	3	1	3	1	5	8	0
I	8	4	3	5	10	5	1	0
J	5	3	3	5	4	5	3	0
K	7	7	8	10	2	3	4	0
L	**53**	**11**	**3**	**2**	**1**	**0**	**0**	**0**
M	23	27	9	2	0	0	0	0
N	19	9	29	4	1	1	0	0
O	7	3	0	1	1	0	0	0

ii) If you were the patient, would you have liked to be told about the mistake?

a. yes 77 90%
b. no 9 10%

2 blanks

CASE 4

The doctor, by mistake, gives a wrong and probably lethal dose of medication to an 80-year-old patient suffering from very high blood pressure. Instead of giving the proper dose of 100 milligrams, the doctor misread the vial and gave 1000 milligrams. The patient appears lucid, though clearly very unwell, and asks the doctor if the reaction is normal. The doctor knows that it's likely to be a matter of minutes before the patient loses consciousness and dies.

Qu. 12. Should the doctor inform the patient of his/her mistake?

a. yes 37 43%
b. no 50 57%

1 blank

i) If NO, which of the following should the doctor say:

a. Yes, everything's fine. You should fall asleep soon 5
b. Don't worry, I'll make sure you're as comfortable as possible 22
c. The medicine I gave you should make you feel very sleepy 24

ii) In deciding whether or not the doctor should inform the patient of the error, what was/were your main reason(s)? (please rank your reasons in order of importance)

a. You believe disclosing the information would cause more harm than good
b. The doctor should not wish to make the patient's last moments more painful than is absolutely necessary
c. The doctor may get into legal difficulties or into trouble with the hospital authorities
d. You feel the doctor has a duty to be honest to the patient about his/her mistake
e. You believe that, if told, the patient might be enabled to state an important request or to pray
f. You feel the doctor should apologise to the patient before the patient dies
g. You believe the patient has a 'right to know' the truth
h. Other, please specify (please write below):

Option	Pref. 1	P2	P3	P4	P5	P6	P7	P8
A	19	15	2	0	1	2	1	2
B	**33**	**11**	**3**	**2**	**1**	**1**	**3**	**0**
C	4	0	3	2	2	3	4	0
D	12	6	10	8	3	3	1	0
E	19	15	6	3	1	3	1	0
F	9	4	8	7	6	1	0	1
G	11	10	6	5	4	2	2	1
H	4	1	9	0	0	0	0	0

iii) If you were the patient, would you have liked to be told the truth?

a. yes 42 49%
b. no 43 51%

2 blanks, 1 'I don't know'

CASE 5

The doctor puts the patient on the waiting list for a heart transplant. The expected waiting time is 9 months. The doctor knows that 40% of patients die while on the waiting list.

Qu. 13. Should the doctor tell the patient this?

a. no 19 22%

b. yes 69 78%

i) In this situation, do you consider not telling the patient a form of deception?

a. yes 68 78%
b. no 19 22%

1 blank

ii) The patient is poor. Should the doctor tell the patient that, if done privately, the operation could be done very soon?

a. no 25 29%
b. yes 62 71%

1 blank

iii) The patient, worried by the 9-month delay, asks the doctor "but won't I die before my turn?" Should the doctor:

a. say that many patients on the waiting list *do* get their operation in time 19 22%
b. say that unfortunately many patients do die on the waiting list but that there is a 60% chance that he/she will get the operation in time 41 47%
c. say that some patients die while waiting but that he/she should remain hopeful 26 30%
d. Other, please specify (please write below): 1 1%

1 blank

If you did *not* choose b) please answer the question below:

iv) The patient then asks: 'doctor, what percentage of people die while still on the waiting list?'. The doctor is sure that it is roughly 40%. Should the doctor:

a. tell the patient this fact 47
b. repeat that many people *do* get their operation in time. 4
c. quote a lower percentage 0
d. claim that he/she doesn't know exactly 7
e. other, please specify (please write below) 1

CASE 6

Mr Smith is taken to hospital following a heart attack. He is recovering in intensive care and his chances of a full recovery are good. On examination, doctors discover that Mr Smith has a form of cancer which is quite successfully treatable with modern drugs and radiotherapy. Mr Smith's father died from this type of cancer years before and it is known that Mr Smith has a great fear of the disease. His blood pressure is in poor control and minimizing stress is medically desirable to lower the risks of another heart attack.

Qu.14. Should the doctor, at this time, tell Mr Smith that he has a form of cancer?

a.	**yes**	**37**	**43%**
b.	no	50	57%

1 blank

ii) Do you think *not* revealing this information is a form of deception?

a.	**yes**	**56**	**64%**
b.	no	31	36%

1 blank

iii) If Mr Smith asked a question which could only be truthfully answered by telling him that he has this cancer, would the doctor be justified in deceiving his patient?

a.	yes	15	17%
b.	**no**	**73**	**83%**

iv) Would it matter if the doctor deceived the patient by lying or if he deceived him by other means, such as cleverly answering a different question?

a.	**no, both are the same**	**51**	**59%**
b.	yes, lying is preferable to using other means of deception	0	0%
c.	yes, deception *without* lying is preferable	17	20%
d.	I don't know	18	21%

2 blanks

CASE 7

A 26-year-old woman, with two young children, is suffering from a serious form of cancer. She is having radiation therapy, chemotherapy, oxygen and morphine for pain relief several times a day. Although fragile, she is energetic and hopeful. One day, she tells the doctor of her "feeling" that "things aren't going as well as people tell me they are" and of her hopes that he [the doctor] will have new "tricks" up his sleeve. She says that she read of a woman dying of leukaemia who wrote stories for her children to remember her by. She continues: "My best friend said I should do the same for my kids, but I don't think I'm *that* far gone, am I, Doctor?" She probably *is* that far gone and is likely to die within a few months. Although in practice discussions between the doctor and patient will continue over a period of time, at this stage:

Qu. 15. Should the doctor:

a.	tactfully tell her that she probably is that far gone	30	34%
b.	tell her reassuringly that she isn't that far gone	0	0%

c. avoid answering the question directly and encourage her to remain hopeful
5 6%

d. tell her that he/she doesn't know for sure but that it would be sensible to write the stories because it's a good idea to hope for the best but prepare for the worst **51 58%**

e. other, please specify (please write below): 2 2%

i) Do you think your answer involved deceiving the patient?

a. yes 7 8%
b. **no** **80** **92%**

1 blank

ii) In selecting your answer, what was/were your main reason(s) (please rank your reasons in order of importance)

a. The doctor should not make the quality of her life worse by making her lose hope
b. You believe she had a better chance of living longer if not told the truth
c. You believe she had a right to know the truth
d. You felt the doctor had a duty to tell her so that she could make better informed decisions about her future.
e. You believe she would find out later anyway
f. Other, please write below:

Option	Pref. 1	P2	P3	P4	P5	P6
A	30	1	6	4	6	3
B	3	9	8	6	4	7
C	20	24	5	3	1	0
D	**41**	**15**	**2**	**3**	**1**	**0**
E	5	5	17	5	5	0
F	6	1	1	0	1	1

SECTION 3

Qu. 16. How often do you think deception (e.g., lying, being 'economical with the truth', distorting truth, concealing information, etc.) is used by doctors?

a. Often **47** **54%**
b. Occasionally 28 32%
c. Rarely 2 2%
d. Never 0 0
e. I don't know 10 11%

1 blank

Qu. 16a. How often do you think doctors use deception in order to benefit their patients?

a. Often	30	34%
b. Occasionally	**34**	**39%**
c. Rarely	6	7%
d. Never	2	2%
e. I don't know	15	17%

1 blank

Qu. 17. Do you believe that it is ever acceptable for doctors to deceive their patients?

a. yes	**52**	**60%**
b. no	34	40%

2 blanks

Qu. 18. Do you think that most patients would find it morally acceptable for their doctor to deceive them if the doctor believed such deception was in their best interests?

a. yes	23	26%
b. no	**43**	**49%**
c. I don't know	21	24%

1 blank

Qu. 19. As a patient, would you find it morally acceptable for your doctor to deceive you if he/she believed such deception was in your best interests?

a. yes	18	21%
b. no	**59**	**68%**
c. I don't know	10	11%

1 blank

Qu. 20. Do you think a GP or hospital doctor has ever deceived you, a relative or a friend?

a. yes	**51**	**59%**
b. no	19	22%
c. I don't know	17	20%

1 blank

Qu. 21. Which do you consider worse: a doctor who withholds important information from you or a doctor who lies to you about important information?

a. the doctor withholding information is worse than the doctor lying	2	2%
b. the doctor lying is worse than the doctor withholding information	32	39%

c. both are equally bad **49** **59%**

5 blanks

Qu. 21a. Do you think it is *ever* acceptable to deceive someone in that person's best interests?

a. yes	**59**	**68%**
b. no	28	32%

1 blank

Qu. 22. Has thinking about this questionnaire affected your views on truth-telling and deception in medicine?

a. yes	36	42%
b. no	**50**	**58%**

2 blanks

Qu. 23. Do you think a doctor and his or her patients should know what each other's views are on these issues (i.e., truth-telling and benignly intended deception)?

a. no	12	14%
b. yes	**64**	**74%**
c. I don't know	11	13%

1 blank

Appendix G

Summary of results for public questionnaire (n=56)

Qu. 1. *Please select your age group*

a.	19 or under	1	2%
b.	**20-29**	**17**	**31%**
c.	30-39	14	26%
d.	40-49	11	20%
e.	50-59	9	17%
f.	60-69	2	4%
g.	70+	0	0%

2 blanks

Qu. 2. *Please indicate your gender*

a.	male	24	43%
b.	**female**	**32**	**57%**

Qu. 3. *Please select the option closest to your educational level*

a.	not obtained any examination qualifications	0	0%
b.	obtained a basic secondary school qualification (e.g., GCSEs/O-levels)	6	11%
c.	obtained an advanced level qualification (e.g., AS/A-levels, GNVQs)	8	15%
d.	**obtained a University degree**	**22**	**40%**
e.	obtained a postgraduate degree	19	35%

1 blank

Qu. 4 *What best describes your household's income?*

f.	less than £10 000	7	13%
g.	£10 001 to £20 000	2	4%
h.	£20 001 to £30 000	9	17%
i.	**£30 001 to £50 000**	**18**	**34%**
j.	more than £50 000	17	32%

3 blanks

SECTION 2 – CASE VIGNETTES

CASE 1

Susan is an 18-year-old girl wishing to donate a kidney to her father, John, who has a life-threatening kidney disease. Susan and John are very close. During routine blood tests, the doctors discover that John is not, in fact, Susan's *biological* father, although Susan could still donate her kidney to him.

Qu. 7. Should the doctor in charge tell this information to Susan and her father?

a.	yes	17	30%
b.	**no**	**39**	**70%**

Qu. 8. What was/were your main reason(s) for choosing your answer? (please rank your reasons in order of importance, i.e., 1 for most important, 2 for next most important, and so on. Choose as many answers as you wish.)

a. You believe telling the information would cause more harm than good
b. Telling the information might destroy the family harmony
c. The patients did not ask for this information
d. The test was not done to discover whether or not the patients were biologically related.
e. You feel the doctor has a duty to provide enough information for the patient to make an informed decision.
f. You believe both the daughter and father have a 'right to know' the truth
g. Other, please specify (please write answer in space below):

Option	Pref. 1	P2	P3	P4	P5	P6	P7
A	**14**	**11**	**4**	**0**	**0**	**0**	**0**
B	3	7	6	3	0	1	0
C	6	13	6	2	0	1	0
D	**15**	**7**	**8**	**4**	**0**	**0**	**0**
E	10	3	2	1	2	1	0
F	9	2	0	1	1	0	1
G	2	0	1	1	0	0	0

Qu. 9. Do you think NOT giving the information is a form of deception?

a.	yes	20	37%
b.	**no**	**34**	**63%**

2 blanks

ii) If you were in Susan's position, would you want to be told the truth?

a.	**yes**	**29**	**53%**

b. no 25 45%

1 blank, 1 'possibly'

CASE 2

Following a serious car accident, a 26-year-old patient is about to have a life-saving operation which, even if successful, will leave him unable to walk. The patient is a keen climber and has told the doctor that he does not want to live if he cannot walk again. He asks the doctor a few hours before the operation whether he will be able to walk again. The doctor knows that his chances are less than one in a hundred.

Qu. 10. Which answer should the doctor give?

a. Don't worry, we'll do the best we can 15 18%
b. I've seen patients with your condition walk again, so let's go for it 11 20%
c. Of course you will. Don't worry about it now 1 2%
d. **I'm afraid there's very little chance you'll walk again, but we'll do our best 29 52%**

CASE 3

The doctor, by mistake, gives the wrong dose of medication to an 80-year-old patient. The mistake is minor and the side-effects of the overdose will disappear in a couple of hours, but the patient is, at present, clearly uncomfortable. The patient asks the doctor if her reaction is normal.

Qu. 11. Should the doctor inform the patient of the mistake?

a. **yes 47 84%**
b. no 9 16%

i) What was/were your main reason(s) for choosing your answer (please rank your reasons in order of importance)

h. You believe disclosing the information would cause more harm than good
i. The doctor should not wish to destroy the trust between himself/herself and the patient
j. The doctor may get into legal difficulties or into trouble with the hospital authorities
k. You believe the consequences of the mistake are trivial
l. **You feel the doctor has a duty to be honest to the patient about his/her mistake**
m. You believe the patient has a 'right to know' the truth
n. You believe the doctor should apologise to the patient for his/her mistake

o. Other, please specify (please write below):

Option	Pref. 1	P2	P3	P4	P5	P6	P7	P8
H	5	3	0	0	0	0	4	0
I	5	9	5	0	0	1	1	0
J	1	1	1	3	0	2	0	1
K	5	1	7	2	2	2	0	0
L	**33**	**8**	**1**	**0**	**0**	**0**	**0**	**0**
M	4	13	5	1	1	0	0	0
N	4	13	11	3	1	0	0	0
O	3	2	2	1	0	0	0	0

ii) If you were the patient, would you have liked to be told about the mistake?

a. yes 49 88%
b. no 7 13%

CASE 4

The doctor, by mistake, gives a wrong and probably lethal dose of medication to an 80-year-old patient suffering from very high blood pressure. Instead of giving the proper dose of 100 milligrams, the doctor misread the vial and gave 1000 milligrams. The patient appears lucid, though clearly very unwell, and asks the doctor if the reaction is normal. The doctor knows that it's likely to be a matter of minutes before the patient loses consciousness and dies.

Qu. 12. Should the doctor inform the patient of his/her mistake?

a. yes 32 58%
b. no 23 42%

1 blank

i) If NO, which of the following should the doctor say:

a. Yes, everything's fine. You should fall asleep soon 4
b. Don't worry, I'll make sure you're as comfortable as possible 11
c. The medicine I gave you should make you feel very sleepy 11

1 person put 'b' and 'c' – both were counted.

ii) In deciding whether or not the doctor should inform the patient of the error, what was/were your main reason(s)? (please rank your reasons in order of importance)

a. You believe disclosing the information would cause more harm than good

b. The doctor should not wish to make the patient's last moments more painful than is absolutely necessary
c. The doctor may get into legal difficulties or into trouble with the hospital authorities
d. You feel the doctor has a duty to be honest to the patient about his/her mistake
e. You believe that, if told, the patient might be enabled to state an important request or to pray
f. You feel the doctor should apologise to the patient before the patient dies
g. You believe the patient has a 'right to know' the truth
h. Other, please specify (please write below):

Option	Pref. 1	P2	P3	P4	P5	P6	P7	P8
A	8	9	1	0	0	0	1	0
B	15	6	0	0	0	1	1	0
C	0	0	2	1	0	2	1	1
D	10	10	7	0	1	1	0	0
E	**18**	**8**	**4**	**3**	**0**	**0**	**0**	**0**
F	1	3	4	7	1	0	0	1
G	6	5	6	2	1	0	0	0
H	1	2	2	0	0	0	0	0

iii) If you were the patient, would you have liked to be told the truth?

a. yes 33 62%
b. no 20 38%

3 blanks

CASE 5

The doctor puts the patient on the waiting list for a heart transplant. The expected waiting time is 9 months. The doctor knows that 40% of patients die while on the waiting list.

Qu. 13. Should the doctor tell the patient this?

a. no 11 20%
b. yes 45 80%

i) In this situation, do you consider not telling the patient a form of deception?

a. yes 44 79%
b. no 12 21%

ii) The patient is poor. Should the doctor tell the patient that, if done privately, the operation could be done very soon?

a. no 10 18%

b. yes 45 82%

1 blank

iii) The patient, worried by the 9-month delay, asks the doctor "but won't I die before my turn?" Should the doctor:

a. say that many patients on the waiting list *do* get their operation in time
15 18%
b. say that unfortunately many patients do die on the waiting list but that there is a 60% chance that he/she will get the operation in time 28 51%
c. say that some patients die while waiting but that he/she should remain hopeful
11 18%
d. Other, please specify (please write below): *1 2%*

1 blank

If you did *not* choose b) please answer the question below:

iv) The patient then asks: 'doctor, what percentage of people die while still on the waiting list?'. The doctor is sure that it is roughly 40%. Should the doctor:

a. tell the patient this fact	**19**
b. repeat that many people *do* get their operation *in time*	*3*
c. quote a lower percentage	*0*
d. claim that he/she doesn't know exactly	1
e. other, please specify (please write below)	3

CASE 6

Mr Smith is taken to hospital following a heart attack. He is recovering in intensive care and his chances of a full recovery are good. On examination, doctors discover that Mr Smith has a form of cancer which is quite successfully treatable with modern drugs and radiotherapy. Mr Smith's father died from this type of cancer years before and it is known that Mr Smith has a great fear of the disease. His blood pressure is in poor control and minimizing stress is medically desirable to lower the risks of another heart attack.

Qu.14. Should the doctor, at this time, tell Mr Smith that he has a form of cancer?

a. yes	9	16%
b. no	**46**	**84%**

1 blank

ii) Do you think *not* revealing this information is a form of deception?

a. yes	**29**	**53%**
b. no	26	47%

1 blank

iii) If Mr Smith asked a question which could only be truthfully answered by telling him that he has this cancer, would the doctor be justified in deceiving his patient?

a.	yes	16	30%
b.	**no**	**38**	**70%**

2 blanks

iv) Would it matter if the doctor deceived the patient by lying or if he deceived him by other means, such as cleverly answering a different question?

a.	**no, both are the same**	**27**	**52%**
b.	yes, lying is preferable to using other means of deception	0	0%
c.	yes, deception *without* lying is preferable	20	38%
d.	I don't know	5	10%

4 blanks

CASE 7

A 26-year-old woman, with two young children, is suffering from a serious form of cancer. She is having radiation therapy, chemotherapy, oxygen and morphine for pain relief several times a day. Although fragile, she is energetic and hopeful. One day, she tells the doctor of her "feeling" that "things aren't going as well as people tell me they are" and of her hopes that he [the doctor] will have new "tricks" up his sleeve. She says that she read of a woman dying of leukaemia who wrote stories for her children to remember her by. She continues: "my best friend said I should do the same for my kids, but I don't think I'm *that* far gone, am I, Doctor?" She probably *is* that far gone and is likely to die within a few months. Although in practice discussions between the doctor and patient will continue over a period of time, at this stage:

Qu. 15. Should the doctor:

a.	tactfully tell her that she probably is that far gone	20	36%
b.	Tell her reassuringly that she isn't that far gone	1	2%
c.	avoid answering the question directly and encourage her to remain hopeful	3	5%
d.	**tell her that he/she doesn't know for sure but that it would be sensible to write the stories because it's a good idea to hope for the best but prepare for the worst**	**30**	**55%**
e.	other, please specify (please write below):	1	2%

1 blank

i) Do you think your answer involved deceiving the patient?

a. yes 7 13%
b. no 47 87%

1 blank, 1 'maybe'

ii) In selecting your answer, what was/were your main reason(s) (please rank your reasons in order of importance)

a. The doctor should not make the quality of her life worse by making her lose hope
b. You believe she had a better chance of living longer if not told the truth
c. You believe she had a right to know the truth
d. You felt the doctor had a duty to tell her so that she could make better informed decisions about her future.
e. You believe she would find out later anyway
f. Other, please write below:

Option	Pref. 1	P2	P3	P4	P5	P6
A	12	7	1	1	1	0
B	5	2	1	1	1	1
C	11	8	4	2	0	0
D	**21**	**9**	**0**	**1**	**1**	**0**
E	1	3	8	0	1	0
F	7	0	2	0	0	0

1 blank

SECTION 3

Qu. 16. How often do you think deception (e.g., lying, being 'economical with the truth', distorting truth, concealing information, etc.) is used by doctors?

a. Often 17 30%
b. Occasionally 24 43%
c. Rarely 5 9%
d. Never 0 0%
e. I don't know 10 18%

Qu. 16a. How often do you think doctors use deception in order to benefit their patients?

a. Often 12 21%
b. Occasionally 33 58%
c. Rarely 6 11%
d. Never 0 0%
e. I don't know 6 11%

1 selected 'b & c' – both answers counted

Qu. 17. Do you believe that it is ever acceptable for doctors to deceive their patients?

a. yes	**44**	**81%**
b. no	10	19%

2 blanks

Qu. 18. Do you think that most patients would find it morally acceptable for their doctor to deceive them if the doctor believed such deception was in their best interests?

a. yes	**24**	**44%**
b. no	16	29%
c. I don't know	15	27%

1 blank

Qu. 19. As a patient, would you find it morally acceptable for your doctor to deceive you if he/she believed such deception was in your best interests?

a. yes	**28**	**50%**
b. no	19	34%
c. I don't know	8	14%

1 'no clear answer'

Qu. 20. Do you think a GP or hospital doctor has ever deceived you, a relative or a friend?

a. yes	15	27%
b. no	18	32%
c. I don't know	**22**	**39%**

1 'possibly'

Qu. 21. Which do you consider worse: a doctor who withholds important information from you or a doctor who lies to you about important information?

a. the doctor withholding information is worse than the doctor lying	1	2%
b. the doctor lying is worse than the doctor withholding information	**32**	**60%**
c. both are equally bad	20	38%

3 blanks

Qu. 21a. Do you think it is *ever* acceptable to deceive someone in that person's best interests?

a. yes	**48**	**89%**
b. no	6	11%

2 blanks

Qu. 22. Has thinking about this questionnaire affected your views on truth-telling and deception in medicine?

a.	yes	24	44%
b.	**no**	**31**	**56%**

1 blank

Qu. 23. Do you think a doctor and his or her patients should know what each other's views are on these issues (i.e., truth-telling and benignly intended deception)?

a.	no	7	13%
b.	**yes**	**40**	**73%**
c.	I don't know	8	15%

1 blank

Appendix H

Truth-Telling in the Doctor-Patient Relationship: a Case Analysis*

Medical Background

An 18-year-old woman, Miss P, approaches the transplant centre stating that she would like to donate a kidney to her father. She appears to be highly motivated to donate, she is healthy, and the testing indicates that she is medically suitable.

The potential recipient, Mr P, is a 50-year-old man who has polycystic kidney disease. He has been on haemodialysis for 6 months, but he has noticed that he has deteriorating strength and does not feel well on dialysis.

Transplantation is considered the best form of treatment for his end-stage renal disease (ESRD). The waiting time for a cadaveric transplant is approximately 4-6 years and the results of transplantation from living donors are better than those obtained from cadaveric donors.

HLA testing shows that Mr and Miss P are a one-antigen match, which means they cannot be genetically related. The test is repeated and the results are confirmed. Neither the father nor the daughter give any indication that they believe they are not blood relatives. The testing was not done to establish paternity and from a medical point of view the findings do not *preclude* Miss P from donating to Mr P.

Psychosocial Background

Miss P is a full-time student with a part-time job. She lives with her (presumed) father and stepmother. Miss P was born abroad and her parents were not married. When her parents separated, Mr P immigrated to North America with his daughter. Miss P has had no further contact with her birth mother. Mr P married 6 years ago. Miss P states that she has a good relationship with her father and stepmother[289].

This case, based on a real case published in the journal *Seminars in Dialysis* in 2002, illustrates the fascinating complexity of doctors' decisions to disclose information. I will use it as a springboard to discuss several practical and theoretical issues relating to truth-telling in the doctor-patient relationship.

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* At the time of writing (January 2006), this appendix is due to appear as a 'Case Study' in a forthcoming issue of the journal *Clinical Ethics*[270].

THE MAIN MORAL DILEMMA

A moral dilemma arises when an agent is morally required to perform two or more actions but cannot do one without failing to do the other(s). Although the present case raises several moral issues, the main dilemma concerns the transplant team's decision to disclose - or not to disclose - the non-paternity to Miss P and her (presumed) father. Should the team reveal the unexpected finding to their patients, thereby fulfilling one set of duties, or should they withhold this information, fulfilling another set of duties. Is this a *genuine* moral dilemma, where the weights of the competing duties pull equally in opposite directions, or does it merely resemble such a dilemma?

ANALYSIS

In examining both horns of a dilemma, it is useful to discern the arguments for and against each alternative.

Moral arguments in favour of non-disclosure

1. *"more harm than good"*

This argument rests on the assumption that disclosing the information is more likely to harm the patients than to benefit them. The harm may take several forms: a) the patients might become psychologically distressed by the news, b) the daughter might refuse to donate her kidney with dire consequences for her presumed father, c) the presumed father might decline the kidney with equally bad consequences as b), or d) the relationship between the family members may be irrevocably damaged and the wellbeing of each member may be reduced by the disintegration of the family unit.

These harmful possibilities may damage *the* morale of the transplant team. Furthermore, if the outraged patients argue that they never agreed to *such a disclosure,* the trust in the transplant unit may also be negatively affected. The patients may feel *that their* trust has been breached. This breach of trust may be considered a harm in itself, irrespective of any *ensuing loss* of trust.

2. ***"no duty to disclose"***

Doctors do not have a duty to disclose *everything* about a patient's medical condition. If a patient with lung cancer asked his oncologist to tell him "everything he knew" about the condition, the oncologist would be under no obligation to spend hours discussing the minutiae of molecular biology, sputum cytology, low-dose helical computed tomography, lung cancer epidemiology and so on. Such a request would clearly be unreasonable. Doctors should disclose medically relevant information which patients could reasonably expect (i.e., whose expectation would be supported by good reasons as judged from an external perspective) to be told. This argument assumes that the non-paternity is irrelevant to Miss P's decision to offer her kidney, or that the patients' hypothetical expectation to be informed of this would be unreasonable. Moreover, as there is no way of knowing whether the patients would like to be told of the news, disclosure might violate their right not to know. A right not to know entails a correlative duty not to disclose.

3. ***"not the purpose of the test"***

Even if the misattributed paternity were medically relevant, the test was conducted specifically to ascertain the tissue compatibility between Miss P and Mr P, *not* to discover whether or not the patients were biologically related. For this reason (the argument goes), the result should not be disclosed.

Moral arguments in favour of disclosure

1. ***"more good than harm"***

Telling the truth, although distressing in the short term, will result in more benefits than harm in the long run. The patients may appreciate the honesty of the transplant team. Disclosing the information might also prevent a subsequent *fracas* and loss of trust if the patients later discover the 'truth'.

Another possible benefit is that Miss P might be relieved that, genetically free from polycystic kidney disease, she will not pass on the condition to any progeny. Mr P too may be relieved that Miss P did not inherit the rogue genes. Note, however, that their fears could be dispelled without revealing the non-paternity: "you'll be pleased *to know that* you have not inherited the genes for polycystic kidney disease!".

Finally, one can argue that there is something intrinsically good about respecting people's autonomy (roughly, their ability to make deliberated choices for themselves). Providing the information and empowering patients to make informed decisions is itself a moral good, irrespective of the consequences. With regards to cases involving genetic relatedness, some have claimed that knowing one's genetic parentage is crucial to an individual's identity formation and thus that people have a right to know their immediate genetic lineage[290].

2. *"necessary for informed consent"*

To obtain valid consent, a doctor should disclose any details that will help the patient make an informed decision. A failure to reveal the non-paternity will mean that Miss P's decision to donate – and Mr P's decision to accept – the kidney will be based on false information (unless they are already aware of this fact). Although many would disapprove of such an action, it is conceivable that Miss P would decline to offer her kidney in the newfound knowledge that she is not biologically related to her father. Despite possible social and moral condemnation, it would be within her right to renege on her decision. Similarly, Mr P might decide to refuse the kidney if he discovered that she was not her 'true' daughter. As informed consent is a cornerstone of ethical medical practice, doctors have a duty to disclose enough information to facilitate such consent.

DISCUSSION

There are, it seems, good arguments both for and against disclosure. The next step in the ethical analysis is to assess the relative strengths of the various arguments and to examine the issues that they raise.

The harm-benefit calculus

Both the pro- and anti-disclosure camps appeal to a harm-benefit calculus to support their position. The analysis above reveals the multi-faceted aspect of harm and benefit. Harm is not limited to medical harm, but includes a range of other harms, from psychological distress to a breach of trust by the medical profession. Balancing these radically *different* types of harm is a notoriously difficult exercise. This is

compounded by the fact that what is harmful is not necessarily morally wrong. One can harm a person without wronging them (e.g. punching a violent aggressor in self-defense) and, conversely, one can wrong an individual without harming them (e.g. secretly stealing £10 from a multi-millionaire)[291]. From performing invasive procedures to breaking bad news, distress is an unavoidable reality in medicine. Information about a patient's health should not be withheld simply because it will minimize distress.

The "balancing act" itself - how one compares two or more radically different harms - is value-laden. When making decisions, agents may bring into their evaluation unspoken beliefs, assumptions and prejudices. The belief that patients want and *should* be told a bad prognosis, for example, reflects the dominant view in many Western countries but would be held by few in places such as China.[188] In Lebanon, Singapore, China and Japan, it is not unusual for doctors to withhold a grim diagnosis from patients[184 185 188 197]. And even in the West, Gordon and Paci have shown that the candid, individualistic 'American approach' to truth-telling to patients is viewed by many Italians as 'very harsh, irresponsible, lonely, naïve'[292]. This inescapable ideological 'baggage' complicates the ethical evaluation, requiring an awareness of the often hidden assumptions on which the calculation is based.

Even with a clear understanding of what should count as a harm and a benefit, there is much empirical uncertainty surrounding which of the two alternatives would lead to the most desirable state of affairs. For instance, how likely is it that the patients will later find out about their genetic non-relatedness and, if they do, that they will know that the transplant team were aware of the fact? Will such a realization necessarily lead to a loss of trust in the transplant team and in the medical profession as a whole? What is the probability of Miss P refusing to donate her kidney if informed of the non-paternity? These are hypothetical questions without clear-cut answers. Existing empirical studies may give the team some indication of what the answers might be, but they cannot guarantee that *these* patients will follow the trend depicted in general studies. The currently unknowable answers to these empirical questions injects a sizeable amount of uncertainty in the harm-benefit assessment.

If certainty is an unreachable ideal, our eventual decision will involve some degree of what Berlin calls 'moral risk'[284]. Our choice, despite our best efforts, may lead to terrible consequences. In the present case, it is quite possible that, in the manner of a Greek tragedy, disclosing the information will 'ruin' the lives of the two patients.

It is unclear, in the present case, which of the two horns will cause less distress. Furthermore, I have claimed that distress *is an insufficient criterion* for making a decision. In light of this uncertainty, I should perhaps focus on *whether the patients* have a right to be told the truth.

Telling the truth

What does it mean to tell the truth? It cannot mean telling any old truth. If my partner *asks where* I was last night and I reply that the stethoscope was invented in 1816, she will not be satisfied, *however correct* I may be. Rather, we should tell the *relevant* truth. This raises another question: what *is relevant? The case* above highlights the ambiguity of relevance. The non-paternity is not relevant *to the medical possibility* of transplanting the kidney from Miss P to her father. For this reason, some will say that 'telling the truth' only involves informing the patients that the transplant can proceed.

On the other hand, the non-paternity is potentially relevant to her *decision* to offer her kidney (and Mr P's decision to accept it). It is also relevant in that it may alter her world-view and self-concept, and may affect her decision to have children depending on her knowledge of her genetic make-up. Furthermore, whether or not she donates the organ, the information is medically relevant since if she donates the kidney she will (probably) improve the recipient's health and endanger her own and, if she refuses to donate, she will maintain her health and the recipient will not be benefited. There are health implications either way. Under this interpretation, 'telling the truth' will require disclosing the information. Depending on which sense of relevance one chooses, the non-paternity may or may not be relevant and this judgement will have knock-on effects on how one interprets 'telling the truth'.

Even if we accept that the finding is relevant in some respects, it is not obvious that there is a duty to disclose the relevant truth. On the bus, I may spot that the person next to me has his zip undone. I may deem this information relevant to him, yet I am under no obligation to correct his presumed false belief that he *is* properly zipped. The same applies if I overhear someone at the bus stop utter an incorrect assertion, even if I judge that it would be in his interest to be corrected. Alternatively, a patient may not wish to be told a relevant truth and, in many circumstances, we should respect this 'right not to know'. As I argued earlier, doctors have no obligation to volunteer everything that they consider relevant to their patients' health (e.g. the health benefits of various foods). There has to be a reasonable expectation that the relevant truth be told.

Applied to this case, the question is: if Miss and Mr P expected the transplant team to disclose the information, would their expectation be reasonable? The strong moral reasons in favour of disclosure suggest the answer is 'yes'. This holds true even if we believe that the countervailing reasons are weightier and that the information should be withheld. Their expectation *not* to be told the truth would also be reasonable, based on the arguments against disclosure listed earlier. In short, the patients can reasonably expect to be told and not to be told. The notion of 'reasonable expectation' does not help much in such cases. The dilemma still remains.

The obligation to disclose relevant, reasonably expected truths is not absolute, but prima facie. Under a pluralist moral framework, which acknowledges a plurality of moral values, there may be other considerations that trump the duty to tell the truth. If telling the truth is likely to endanger the life of a frail patient, for example, then my obligation of non-maleficence may trump my duty to tell the truth. In the case at hand, as various moral goods are in play (e.g. trust, personal autonomy, psychological and physical harm), it is again difficult to conclusively weigh the reasons for and against disclosure. The moral agent will have to exercise moral judgement.

Moral judgement

What is meant by 'moral judgement'? Sometimes called 'moral discernment' or 'moral wisdom', philosophers have used vague terms to describe moral judgement.

Kant considered it a 'special talent that cannot be taught but only practised', while Aristotle saw it as a 'perception' of what is right and wrong[100 120]. In the last century, W.D. Ross claimed that there are no rules to assess the relative stringency of conflicting prima facie duties. Instead, we have to rely on a 'sense of our particular duty in particular circumstances'[78]. More recently, Dancy stressed the central role of moral education in the acuity of discernment: 'a contentless ability to discern what matters where it matters, an ability whose presence in us is explained by our having undergone a successful moral education'[121].

There is something mysterious and deeply personal about moral judgement, akin to a moral 'sixth sense' acquired gradually throughout life. Expanding our cultural, intellectual and emotional horizons is likely to develop this sixth sense. Sound moral judgement will sharpen the process of moral analysis, reducing the likelihood of misdiagnosing a problem as a moral dilemma when, in fact, a clear solution exists. Yet, some dilemmas are so complex that even the wisest of the wise will not find a clear-cut solution. As the philosopher Larmore writes, 'in many cases, judgment will be powerless to settle the [moral] conflict'[123].

PERSONAL THOUGHTS AND PRACTICAL RECOMMENDATIONS

So which horn of the dilemma would I choose, and why? I confess that I have struggled for the past two years over this case. I wavered on the relative weight that should be given to the principle of respect for autonomy. Depending on my mood, I opted for disclosure when I gave the principle significant moral weight and opted against it when I gave it a lower priority. In my current phase, no doubt biased by my fickle belief that I would not want to know myself, I would reluctantly choose the non-disclosure horn, based mainly on the potential detrimental effects of disclosure on the patients.

However frustrating, the persistence of my uncertainty reinforced my suspicion that this case represents a genuine moral dilemma. I *ought* to tell the patients about this incidental but profoundly important finding and I really *ought* not to tell them in case they do not want to be told and suffer terribly for the rest of their lives but I cannot

satisfy both *oughts*! Whichever horn I successfully avoid, I will be impaled by the other.

The transplant team are not, in my view, inescapably doomed. As long as they have duly identified and considered the relevant factors, weighed them in a reasonable fashion with the intention of benefiting their patients, then any bad outcome – though regrettable – would not retrospectively make their decision morally wrong. If the decision to disclose the information turns out to yield catastrophic consequences, it does not follow that the team can be blamed for the decision. They would be unlucky, but not morally culpable. As it happens, the team decided to share their unexpected finding with the patients who, although initially shocked and distressed, were grateful for the staff's honesty. Miss P did not revoke her decision to donate the kidney.

Whatever our own position on the case, all will agree that it is desirable to avoid such ethically (and emotionally) difficult situations. Although some moral dilemmas cannot be realistically avoided, the transplant team could take measures to reduce the likelihood of such situations arising again. Arguably, moral agents should not be blamed for making decisions in a genuine moral dilemma since there is, by definition, no preferable alternative, but they may be at fault if they are morally responsible for allowing the dilemma to occur.

One approach would be to set up procedures to resolve the issue prior to the emergence of the problem. A plausible solution suggested by the authors of the original paper would be to inform patients at the outset of the possibility of incidental but potentially important findings (such as non-paternity) and to ask them if they would like such findings to be revealed[289]. This would ensure that any disclosure is tailored to the informational preferences of the individual patient. Armed with this information, the present case would not be a moral dilemma, but a moral problem with a straightforward (though emotionally difficult) solution.

CONCLUSION

Although it is commonly heard that doctors should always 'tell the truth', it is not always clear what constitutes the 'truth' in any given context. I have argued that

doctors have a prima facie duty to disclose relevant truths that patients could reasonably expect to be told. The American Medical Association's Principles of Medical Ethics, which state that a physician 'shall be honest in all professional interactions' and should 'strive to report physicians engaging in deception to appropriate entities' are thus misguided[131]. Honesty, though generally desirable, is not always the best policy. The duty to tell the truth is not absolute, but can be outweighed by other moral considerations, such as the obligation not to cause great and avoidable harm.

In some cases, there will be equally compelling reasons to disclose and to withhold information (i.e., a moral dilemma). When moral agents suspect a moral dilemma, they should ensure that no morally relevant considerations have been omitted and that the justifications for their preferred position are well-argued. Open discussion with colleagues from different personal and professional backgrounds is desirable to appreciate diverse viewpoints, tighten one's arguments and heighten awareness of personal biases. Finally, moral dilemmas should always generate a further discussion about possible ways to avoid similar problems in the future. Asking patients early on in the doctor-patient relationship how much they would like to know is one way to tailor information to the preferences of individual patients[155 283].

Appendix I

What is False Hope?*

Throughout the long history of the doctor-patient relationship, doctors have always had to break bad news to patients. It is only recently, however, that much attention has been devoted to this delicate art. *Medical schools* run classes on communication skills and authors have written many books on the theory and practice of breaking bad news[293-296]. The common guidance is that doctors should be honest without being brutal, whilst all the while maintaining some hope in the patient, however grim the prognosis[293]. A distinction is often made between instilling hope, which is desirable, and instilling 'false' hope, which is not. But how is hope distinct from false hope?

To understand false hope, we must clarify the related notions of hope and expectation. Hope is typically a combination of two elements: 1) a desire that something will happen and 2) a belief that this desire could be fulfilled. So, although I cannot hope to be the fastest Jamaican sprinter in *the world* because I am not Jamaican, I can hope to be the fastest sprinter in *England*. Expectation typically refers to the *belief that* something is likely to happen. For example, I may hope to *win the lottery* (i.e. I desire that my numbers come up and believe that there is remote possibility that they will) but may not expect to win (i.e. I do not believe this will actually happen). This distinction is encapsulated in the oft-heard advice: "You should hope for the best but expect the worst".

False hope arises *when there* is a strong dissociation between hope and expectation, when a terminally ill patient hopes for a cure *and strongly* expects that he will be cured or, less commonly perhaps, when a patient hopes for a realistic outcome and pessimistically expects that it will never happen. The object of a hope - be it a cure for motor neurone disease or a multi-million pound jackpot - does not determine whether or not the hope is false. What makes the hope false is the accompanying expectation and its relationship with what, objectively, is likely to occur.

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* At the time of writing (March 2006), this appendix is due to appear in a forthcoming issue of the *Journal of Clinical Ethics*.

In a scene from the comedy *Dumb & Dumber*, the protagonist Lloyd, played by Jim Carrey, asks his dream girl to estimate the chances of a romance between them[297]. With a grimace, she apologetically mutters "one in a million". His face lights up: "So you're telling me there's a chance!" Lloyd's hope is false not because he wants to date the girl but because his expectation, conveyed by his enthusiastic response, is higher than the situation warrants.

In medicine, talk of hope must thus be supplemented with talk of expectations, in particular managing patients' expectations. In instilling or maintaining hope, doctors should modulate the patients' expectations to avoid sliding into the realm of false hope, which may prevent the patient from exercising his autonomy (i.e. from making decisions based on his own deeply held beliefs and values). This may be difficult when hope and expectation are at opposite extremes. Some patients may be totally unaware of the severity of their illness, waltzing into a consultation with high hopes that a pill or two will resolve the bothersome problem. Yet realigning the patient's hope with reasonable expectations is central to respecting the patient's autonomy and, although members of the public have no obligation to adjust even the wayward expectations of others, doctors are duty-bound to direct the health-related expectations of their patients.

"To hell with autonomy", one might retort, "and long live beneficence!" True hope might indeed be harmful and, at times, even more so than false hope. Anecdotes abound of patients who rapidly declined after their far-fetched hopes and expectations were dashed. However, even on a harm/benefit analysis, true hope usually fares worse than false hope in the short term only. Lloyd is happy in his Fool's Paradise for a while but when his *objet d'amour* mentions her husband, his heart sinks: "Husband? Wait a minute...what was all that one-in-a-million talk?"

Admittedly, there may be rare cases where it is preferable to raise expectations well beyond what cold reason dictates, and where false hope is kinder than true hope: in the minutes before a major, long-awaited operation, when the terrified patient asks if he will be all right, saying reassuringly that all will be fine; when a distraught mother asks if her child suffered in his final moments, saying that he died peacefully; when a

depressed patient contemplates suicide, lifting his spirits with encouraging words. If the two virtues cannot co-exist, humanity should *always precede sincerity.*

In most circumstances, faced with the *unenviable* task of breaking bad news one should maintain the all-important hope whilst guiding patients' expectations to a level roughly equal with one's best prediction of what will occur. It is a precarious juggling act, but a profoundly important one.

Appendix J

Ethics History Sheet*

(to be completed with the patient)

E1. Everyone copes with their illness differently. Some like to know all the details of their illness and treatment, limited information, and some prefer not to know, or to know very little. Do you prefer:

Not to know ☐ Limited information ☐ To know all the details ☐

E2. Any comments.....

.....

.....

E3. Do you feel the information you have had so far has been:

Too little ☐ About right ☐ Too much ☐

E4. Any comments.....

.....

.....

E5. If they ask us, may we talk to your family about your illness? Yes ☐ No ☐

E6. Is there anyone in your family whom you would prefer us not to give information to?

.....

.....

E7. Do you prefer anyone particular to be with you to hear results or to discuss or make important decisions about your care and treatments?

.....

.....

E8. Have you ever written down your wishes about future treatment?

....

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E9. The staff here will always try and advise what is in your best interests, and will discuss this with you whenever possible. It is helpful however to know if you have any particular preferences for or against specific treatments?

.....

.....

E10. If there are any major decisions, do you prefer:

- ☐ For the doctors to make the decisions
- ☐ For the doctors to give you all the information and help you make the decision
- ☐ For you and your family to discuss and decide together
- ☐ Other.....

.....

.....

Name of doctor completing (print):.....

Date of completion:.....