TRUTH OR LIE – SOME ETHICAL DILEMMAS IN THE COMMUNICATION OF A SEVERE DIAGNOSIS

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TRUTH OR LIE – SOME ETHICAL DILEMMAS IN THE COMMUNICATION OF A SEVERE DIAGNOSIS (Abstract): Informing the patient about his disease is a very important issue in the medical practice, thus communication becomes imperative in healthcare services. Communicating the diagnosis of a pathology that doesn’t bear any imminent risk for life is a common procedure for physicians. However, the situation changes drastically in the case of a severe diagnosis or a hopeless prognosis, with terminally ill patients. 

Aim: In this article the authors proceed to a critical analysis of the dilemma of communication or non-communication of a severe diagnosis. 

Material and Methods: The problem of communicating a severe diagnosis is described from a philosophical perspective (in terms of three fundamental ethical theories: Aristotle’s theory of virtue, Kant’s ethical theory and Bentham and Mill's moral theories). At the same time, certain physiological and medical approaches are presented. 

Results and conclusions: In order to avoid any communication conflict, especially considering the particular situation of the seriously ill patient in the context of the contemporary medical activities, the authors propose the debating of two opposing approaches: “the sacred lie principle” and “the justified medical truth” in the physician - patient relation. Keywords: SEVERE DIAGNOSIS COMMUNICATION, MEDICAL ETHICS, INFORMED CONSENT.

Communication is a personal ability that cannot be separated from the human being. It is the process used by individuals to exchange information, using a common and adequate system of signs, symbols and actions that allow both the adjustment of own behavior and the understanding of other people’s behavior (1).

In the physician – patient relation the communication is essential, and its necessity for the communication between the patient and the physician / medical team is widely recognized and proved by researches. Due to its high importance in the medical activity and to the fact that the ability to communicate is not innate, but learned, the study of this topic is more and more frequently included in the medical curricula (2). This approach allows the future physicians to develop themselves globally, combining the professional technical aspects with the communication and rational interpersonal skills that form a “measurable and changeable set of behavior features that can further evolve” (3).

Over the years medicine has considera-
bly increased its complexity and intricacy, imposing over-specialization, through which the areas of expertise of the medical specializations were narrowed and deepened in order to improve performance. The doctor-patient relationship, in turn, has met a number of important changes, becoming much more complex, involving more professionals. On the other hand, the time dedicated to medical consultations has decreased considerably, raising the gap between patient and physician. The commercial character that society imposed on the doctor-patient relationship has also contributed to this, turning the doctor into a service provider under the risk of malpractice accusation in case of breaking the contractual relationship established between him and his patient.

Thus modern medicine has moved the doctor away from his patient, reducing the interpersonal interaction and communication between them, while the technical aspects of the medical profession have become increasingly conspicuous. The emphasis on the scientific and technical side of the modern medical profession in the higher education system has greatly contributed to this state.

Considering the increasing pace of industrialization and bitter preoccupation to heal at any price, placing in the forefront the disease to be treated rather than the patient as a human being, in the recent years, the adequate and effective communication has become increasingly important. There are a certain number of researches proving the importance and the role of social and psychological aspects in the evolution of pathology. The 2004 report of the Institute of Medicine (IOM) in the United States shows that about half of the causes of mortality and morbidity in this country are related to social and behavioral factors which led to the conclusion that the medical standards should incorporate psychological and social knowledge and communication skills in order to create an efficient therapeutic relationship between the physician and his patient, ensuring patient compliance and improving treatment outcomes (4).

Parallel to the technical progress of medicine, doctor-patient relationship has undergone a major transformation by moving from paternalistic model when the doctor makes all the decisions concerning the treatment, towards the relationship of partnership, which promotes patient autonomy, in which doctor and patient work together to identify the best therapeutic solutions. In this type of relationship, the physician invests medical expertise, considering the "best interests" of the patient from the perspective of the given medical data. The patients, in turn, invest their own set of values and life principles as a filter for all the information received. Such doctor-patient relationship, which aims to develop a medical decision by articulating the medical information provided by the physician to the patient's life principles, can be functional only by means of establishing efficient communication between the two parts (5).

THE INFORMED CONSENT OF THE PATIENT

The patient's informed consent has become a reality of the Romanian clinical activity in the last decade. Although it is often regarded as a formal procedure of the patient signing a "document" (in fact, its meaning remains unclear to the patient), which authorizes the necessary medical intervention, according to the national and
international regulations; however, the informed consent tends to overcome the excessive formalization by practically displaying its moral, legal and social advantages (4).

The moral benefits may be limited to the patient’s awareness of his/her own moral value and the right to be treated respectfully by the doctor, as well as the doctor’s moral satisfaction, gained by refraining from unconscious tendencies to dominate, encouraged by his advantageous professional position over the patient's vulnerability and dependence.

The legal advantage of the informed consent, if properly conducted, becomes relevant when used as a means of protection in case of legal action initiated by the patient against the physician.

The social benefit derives from the fact that getting an informed consent can be considered an education process with informative features, since a certain sequence of the medical science development is revealed to the subject that enhances his knowledge, and at the same time requires him to take the responsibility for his own actions within the therapeutic program, which consolidates the core of personal autonomy. This advantage of the informed consent takes higher importance especially for countries that overcame totalitarian political regimes that inhibited both the individual autonomy and the cultural pattern or collective spirit. The doctors assuming the role of "educator" of the patient supposes an implicit acknowledgment of the ideals of the human rights consigned within the Declaration of Human Rights (1947), but also their contribution to the maintaining and strengthening of these relatively recent acquisitions of the human civilization.

**CONTEMPORARY CIRCUMSTANCES**

Besides the advantages detailed above, informing the patient remains a highly debated problem, both in the academic and clinical terms, when it's a matter of a life-threatening diagnosis. In Western countries, the practice of direct revealing of the lethal diagnosis is consistently implemented since the second half of the twentieth century. This practice is based on the principle of patients’ autonomy, under which he has the right and full power of deliberation – decision concerning his own life regardless of the existential context, justified by clinical need of the patient’s compliance to the therapy (6).

In the Romanian clinical environment, in spite of the globalization trends to create common standards of activity in various fields, including that of medical practice, a denial of adequate or complete information about a patient's diagnosis persists, especially a serious one and it occurs without there being the patient’s prior refusal to be informed, as required by national and international legal practice (for example, the Oviedo Declaration of the European Council in 1996, on the right of "not knowing" stipulates that the information may be waived only if the patient wishes not to be informed).

Sometimes the patient reveals certain ambivalence toward "truth", an uncertain desire to know his diagnosis, which requires the specification of the information that the patient really wants to receive. The patient is frequently not able to understand at once what he is informed about, including the full spectrum of consequences of his disease. At each stage of the disease, we can observe apparent reactions of escape, of denial or avoidance, which should
not be taken as a resignation, but reflect the patient’s resentment and his way to react, which must be accepted and respected. The interweaving of the patient’s responsibility regarding his decision with the support provided by the physician enables the efficient collaboration between the two and excludes the possible conflicts between the "principle of the sacred lie" and "the legitimate medical truth".

In literature there are frequent descriptions of disputes different opinions whether a serious diagnosis should be communicated or not, ranging from total rejection and assessing it as inhuman and accepting it as fundamental right of the patient (7, 8), the doctor often facing the dilemma of informing the patient or not of the serious or terminal stage of the illness.

On one hand, in Romania the legislation forces the physician (under the potential threat of punishment) to inform the patient about his medical condition and the patient has the right to file a complaint of malpractice in case the doctor breaks his right to information. On the other hand, non-disclosure of bad news to patient is based on an attempt to protect the patient, under paternalist approach of the doctor-patient relationship, the doctor being authoritarian by competence, and fully responsible in the relation with the patient, whilst the patient is dependent (subject), and fully confident of the good intentions of the physician towards him. In this type of relationship the physician decides either to inform the patient about a lethal diagnosis or not, with the condition that such decision is taken in accordance with the promotion of the patient's benefit. Since the general, most often accepted perception is that the negative information and especially the one about the state of incurability, produces negative effects (consequences), the doctor, desiring to protect and not to damage the patient, tends to avoid the communication of the diagnosis.

PHILOSOPHICAL PERSPECTIVES

The philosophical valences regarding the dilemma of whether to inform patients suffering from a serious illness will be analyzed considering three fundamental ethical perspectives: the teleological perspective (Aristotle's theory of virtue), the deontological perspective (Kant's ethical theory) and the utilitarian one (Bentham and Mill's moral theories).

Aristotle (9) developed an ethical theory of self-realization according to which we, as human beings, hold potential moral virtues that can and are updated only through practice. Only by proceeding correctly do we become righteous or only by offering do we become generous. But we can, for example, offer too little and then we are considered stingy, or we give too much and then can be considered wasteful. In this context, Aristotle defined virtue as a middle state between two vices, one that is born of excess and the other of deficiency. Thus, generosity is the middle way between of avarice (deficiency), and waste (excess) contrarily, courage is born by avoiding cowardice (deficiency) and at the same time fearfulness (excess), and modesty is the middle way between shyness and naughtiness. In order to live morally and virtuously we must find the midpoint between two extremes. In other words, a life lived virtuously is that the moderate way. If we want to be sober we must consider the "golden middle" of our own perspective, in other words, we must know our own measure.

According to the Aristotelian view, the concept of virtue cannot be applied to all
types of activity as for some behavioral acts there is no middle way. For instance, we can eat and drink moderately (to some extent), but we cannot kill, steal or lie moderately, as these actions themselves are labeled as immoral. Under these circumstances, if the doctor wants to be moral, he must be honest at any time, even towards a patient facing a terminal or serious diagnosis. The moral act is done not under the influence of pressing/stressful circumstances, sometimes rather despite them, but always reasonably. At the same time, according to the Aristotelian view, a virtuous act cannot be committed accidentally, but only as the manifestation of sustainable moral traits of character. Returning to informing the terminal patient, in Aristotelian terms, the appropriate question is not telling the truth or not, but how and when that truth must be told. The answer to this issue, in terms of his theory, is that the truth must be told in a moderate (cautious) way that could mean "the right words in a proper case" avoiding over-information on the one hand and refusal to inform him on the other.

The utilitarian’s theory changes perspective in approaching morality: from virtue and self-development towards the considerations about society and law. Morality is not just a personal matter devoted solely to self-realization (self-becoming), as Aristotle sees it, but it also refers to the common good and public order. Establishing a foundation of moral criticism is an indispensable process of building a better society by means of improving the legislative base. From the utilitarian approach of the two significant representatives (Jeremy Bentham and John Stuart Mill), legislation is the crucial element in achieving individual and general social welfare (10).

Both utilitarian philosophers promote the principle of "maximum happiness for the maximum number of people" as the moral basis of an adequate legislation; according to this principle, an action can be judged as morally right if its consequences are as good as possible for a number of people as large as possible. If legislation promotes such actions and consequences, they are considered appropriate.

Returning to the problem of communicating the diagnosis, we can assume that from the utilitarian perspective, the relationship physician – patient must be guided by laws, codes and social conventions based on the principle of the best consequences for the largest number of individuals. Let us assume that the doctor lies to the patient about the diagnosis, with the good intention of not harming them. As a result, the patient will experience a state of satisfaction/happiness gradually subdued by the persistence or worsening of the illness’s symptoms and ultimately replaced by a deep sense of disappointment that can dangerously affect the patient’s life and, in a bad way, the physician’s life. Therefore, not disclosing the truth cannot be a rule of conduct as it does not maximize the happiness or subdue the pain of a maximum number of individuals. By contrast, utilitarian analysis of consequence shows a new rule of conduct for medical doctors: “the medic must tell the truth to his patients”.

From the Kantian perspective, the priority in ethical evaluation moves from the consequences towards the action itself. According to Kant, each time we act voluntarily, we are guided by certain rules, of which, we may or may not be aware at the time of the action, but which we acknowledge, when we have to justify our behavior to others or to ourselves. In order to distinguish the moral behavior norms
from the immoral ones, Kant formulated the categorical imperative, the most well-known formula: *Act only according to that maxim whereby you can, at the same time, will that it should become a universal law* (11). According to this formula, the maxim is moral if, without contradiction, it is required to be a rule of conduct for everyone, without exception. For example the maxima "*Lie in order to get what you want*" cannot be moral for no one, even the most experienced liar, would accept it (or like it) as a universal rule of behavior. If a person chooses to lie in some cases, they should want to be victimized by a liar, crook or cheat. Presumably, nobody wants to be deceived, so no rational thinker, according to Kant, would accept such maxima.

As for the topic of this paper, from the Kantian perspective, in order to stay a moral person, the doctor, like any other human being, must tell the truth under any circumstances. This *must*, coming not from external constraints, but from the holy will (each man’s duty) to follow their own moral law (or in other words from the categorical imperative of human beings by virtue of freedom, personal autonomy), is by definition (due to universality) the moral law of all people.

From all of the above, we find out that all three ethical approaches reach the same result by different means, namely: non-disclosure of adequate information about their medical condition to the terminal patient is, theoretically, morally unjustified. It should be noted, however, that within these theoretical reflections, slightly modified by empirical necessity, a moderate opinion may be added, according to which the refusal to provide information is still unacceptable; however, it is morally accepted to limit information in order to safeguard the patient’s interest, complying with the requirement of prior critical analysis of the condition, the nature of pathology, the expected evolution and patient’s personality. As stated, this view is possible, provided that it is not the case of some limitation of *content* but merely of an apparent one, with a background in the spirit of Aristotelian, utilitarian and Kantian ethics.

**MEDICAL PERSPECTIVES**

Despite the perspective offered by the philosophical approach, many practitioners argue that providing full and detailed information to the patient with serious diagnosis can lead to the worsening of their state, inducing possible state of depression, anxiety, apathy etc. These assumptions are often rooted in practice (12). On the other hand, communicating serious diagnosis or bad prognosis is one of the most difficult aspects of the doctor-patient communication which, unfortunately, is insufficiently taught during the training of future specialists in our country.

The way of communication and informing the patient is extremely important. How the patient perceives, internalizes and reacts to the information received, strongly depends on the form of communication. Even if the statement is a seriously bad diagnosis, the physician should not try to minimize the importance of information, but tell the truth in an empathic manner, with the aim of actively involving the patient in their recovery. The minimization of the importance of the disease risks to suggest the patient that there is no need to worry or get deeper involved in the therapeutic process, which will lead to a poor therapeutic compliance. Contrarily, the disclosure of reality must be accompanied
by instilling confidence in the physician as well as hope for the better (13).

The act of information in medicine should be individualized while the way of communication must vary from case to case. In order to avoid the negative effects of information, the doctor should get more information about the patient, especially on his values and cultural context from which he comes before disclosing a diagnosis of serious illness or a poor prognosis. A patient may need additional information which requires that the relationship between the doctor and the patient be based on trust and hope. After a longer contact with the patient, the doctor may find important data on the patient’s character and their emotional status that allows him to choose the correct way of providing information about the disease and its prognosis.

In the communication process, patience is essential. The patient’s satisfaction is higher when the duration of the meeting with his doctor is in line with his expectations, especially when the doctor proves to be a real communication partner. Unfortunately, it was found that doctors would listen, on average, just 23 seconds before stopping the patient from the story of his complaints and turn the discussion into another direction. Allocating enough time for discussion allows the patient to better understand the information that must be provided in accessible terms, according to his degree of education and age (14).

There are several studies showing that effective communication in medicine has positive therapeutic effects on short and long term, both at the psychic and somatic level (15).

On short term, good communication creates a state of satisfaction with the interaction with the physician and the medical care received, and promotes adherence to the prescribed treatment and recommendation.

In the long run, good communication is likely to improve the patient’s health condition and quality of life, proved by the resolution of symptoms, especially pain relief and improvement of physiological parameters such as blood pressure and blood sugar level. In addition, it leads to anxiety reduction that has positive effects on the health of the patient.

The efficiency of the communication between doctor and patient is reflected in meeting its goals, among which the most important is to create a therapeutic relationship. Only throughout efficient communication can a doctor withdraw useful information from the patient, based on which the physician can make the best decision together with the patient and his family and launch the therapeutic procedure. In this sense the patient will adopt the appropriate behavior related to his disease and treatment. In order to comply with the medical prescriptions, the potential benefits and risks, the patient must understand and accept the medical diagnosis (16).

Taking into account the results of several studies on the importance and beneficial role of communication in medicine, WHO insisted in recent years on the need to promote the ethical values within medical communication, stating that “information is a basic right for all as health is a priority for the whole world” (3).

An important aspect of the effective communication in medicine is reducing the risk of malpractice claims. An example of this is provided by the Netherlands, a country where about 40% of health care services are provided by family doctors, who go along patients for long periods and estab-
lish with them and their families long term relationships based on trust; this makes patients less likely to act legally against their doctors even if they are mistaken. This last fact is based on the premise that physicians have the best intentions in relation to their patients (18).

**PSYCHOLOGICAL PERSPECTIVES**

In the communication process the doctor and the patient should be placed on equal positions, a condition necessary for providing a partnership, focused on patient autonomy (17).

In his interaction with the patient, the physician should adopt a cognitive empathetic approach that might allow the doctor to get closer to the patient and gain his confidence. It is necessary for the doctor to avoid excessive emotional involvement because it could affect the diagnosis and therapeutic behavior. The "compassionate detachment" helps the doctor to better understand emotions, inner experiences and the patient’s perspective on the disease; it is beneficial for the latter as he does not need pity from his doctor, but understanding and support. The studies show that the empathic communication between the doctor and his patient determines the satisfaction of the latter, the adherence to the treatment and perception of his interaction with the physician as being of good quality. Other studies indicate a lower risk of malpractice claims and obvious improvement of health status of the patient if a relationship is based on empathy (19).

In the process of communication the physician must be prepared for any reaction from the patient, especially when communicating a diagnosis of seriously bad or incurable illness. The patients’ reactions to bad news may be very different and can be placed on a range from stoically facing reality to hysterical manifestation, crying, anger or denial. No matter where he is placed in this continuum, the patient has the right express his emotions in reaction to the diagnosis and prognosis of their disease, and the doctor must allow and even encourage this (14).

Some oncology professionals suggest some ways of dealing with patients with no hope for cure (20). It is proposed to avoid communication of the diagnosis to those patients that never suspected the pathology and are in a good state for the moment. The information can be cautiously suggested to those with a strong character who value truth more than tragic subjectivity, as well as to those who already feel the sad diagnosis and refused a treatment or intervention. In this perspective, the physician’s careful deliberation based on psycho-medical criteria becomes essential, also taking into account the socio-professional and family environment of the incurable patient.

**THE ROLE OF THE FAMILY IN THE DOCTOR - TERMINALLY ILL PATIENTS COMMUNICATION**

In establishing an ethical and collaborative relationship between doctor and terminal patient it is also important to highlight two aspects: vulnerability and limited autonomy of the dying patient and the importance of relationships and family roles.

The current Romanian legislation, connected to Western values and ethical principles, promotes individual patient information and making decisions based on his autonomy. Nevertheless, in some cases these patterns of behavior cannot be achieved in the interaction with some patients. The medical practice and legislation
in many European countries, including ours, provide the possibility that — in case of patients with diminished or absent capacity of decision — the closest kin should take part in the medical decision according to what the patient would want in that situation (21).

Often, the patients' family members want to get as much information as possible about their relatives in serious condition. At times, they might be the ones to hold the most information about the patients. This knowledge could entail greater clinical approach of the latter (22).

We must also consider the situations when the patients, although accompanied by family members, do not feel comfortable being examined in their presence. It can be seen as a violation of their dignity or privacy. Such conflict situations are not rare and an inadequate solution to difficult ethical dilemmas is an additional source of stress (23-25).

Confidence is extremely important in interacting with the medical personnel, both for the patient and his relatives. The lack of information or the inadequate communication can lead to loss of confidence and limitation of the patient in his decision making ability. For the medical staff the situation becomes even more delicate when interacting with patients from particular ethnic groups with cultural values different from those of the majority of population. Some studies on communication between medical staff and patients from certain ethnic groups (Chinese and Asian population in the U.S.) showed that the latter may have less trust in physicians (26, 27) or have a distant attitude towards health care workers.

Such studies show that familiarizing the medical personnel with the behaviors and beliefs of the patients is essential for a good relationship and communication, allowing the identification and resolution of potential conflicts of values (28-31).

**CONCLUSIONS**

Along with the progress of medical science, communication is nowadays thought to be essential in establishing a therapeutic relationship between doctor / healthcare professional and patient. However, communicating the serious diagnosis and prognosis remains a real challenge for the physician, who is often "caught" inside the dilemma of the "principle of sacred lie" and the "legitimate medical truth".

Thus, the solution of this difficult issue of disclosing the serious diagnosis and prognosis is supported both by theoretical, philosophical arguments, and by the results of studies and clinical practice. All these arguments support and promote disclosure of the diagnosis to the patient, no matter how serious, emphasizing the great importance of the way to communicate and the doctor’s ability to morally support the patient, instilling them the confidence they need.

The necessity and importance of communication in medicine result from the essence of the medical profession itself which comprises of a blend between the Asclepian tradition promoting the importance of technical knowledge and critical current practice and the Samaritan tradition that promotes the doctor’s compassion towards his patients the good relationship between physician and patient outlining the humanistic character of medicine.
REFERENCES

Rodica Gramma et al.


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**NEWS**

**TRANSARTERIAL CHEMOEMBOLIZATION FOR HEPATOCELLULAR CARCINOMA**

Transarterial chemoembolization (TACE) is used as treatment for hepatocellular carcinoma. Cytolysis, caused by necrosis of tumour or of non-tumoral parenchyma, may occur days after the procedure and can influence tumour response and liver function. A study by Marquez *et al.* evaluated the impact of cytolysis on tumour response, hepatobiliary complications and survival of patients with liver disease who underwent treatments for hepatocellular carcinoma. The researchers analyzed the associations between cytolysis and radiologic tumor response, as well as adverse hepatobiliary events. Also, they compared the survival rate at 18 months after chemoembolization between the groups with and without cytolysis. The study found that cytolysis was associated with a favourable radiological response, but had no impact on the occurrence of short-term adverse hepatobiliary events or survival at 18 months. (Marquez V, Sylvestre MP, Wartelle-Bladou C, Bouchard L, Perrault P, Grégoire P, Pomier-Layrargues G. Impact of cytolysis following transarterial chemoembolization for hepatocellular carcinoma. *J Gastrointest Oncol*. 2013;4(1):45-52. doi: 10.3978/j.issn.2078-6891. 2012.061).

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