2.3 Truth Telling

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Educational Objectives

1. To understand the relationship of the fundamental ethical principle of autonomy to truth telling
2. To understand the relationship of truth telling (and in contrast, deception) with respect to the process of informed consent
3. To consider the concept of truth telling in the face of clinical uncertainty and/or an unwanted diagnosis

Case

Paul Green is a 71-year-old retired professional who lives with his wife of 45 years. They have two grown children who do not live in the family home. Since retirement, Mr. Green has remained active in several volunteer organizations in his community and also in the outdoor activities of hunting and fishing. He has been referred by his family doctor to a geriatric psychiatrist for evaluation at a memory clinic because of difficulties he was experiencing in remembering things, especially since beginning a strategic planning process with one of his community groups.

Mr. Green was accompanied to the clinic by his wife, who commented that from time to time she had noticed her husband misplacing things about the house and that occasionally he seemed to have difficulty finding words; however, she minimized these things by stating that she felt it was no different from her behaviour and that, between them, they managed to accomplish everything reasonably. She expressed concern that her husband’s father had died almost 15 years earlier after a long battle with Alzheimer’s disease. She said that her husband told her then, and repeated it from time to time over the years, that he would never burden her with having to care for him as he had seen his mother do and that he would end his own life if that time came. Mrs. Green also said that one of her husband’s cousins had taken his own life shortly after developing memory problems and that her husband said his cousin had done the right thing. She pleaded that her husband not be told about the possibility of Alzheimer’s disease if that was a consideration.

With respect to Mr. Green’s assessment at the clinic, there was no evidence of mood disturbance and no apparent deficits in the psychiatric clinical interview other than the examples the couple provided and a Mini-Mental Status Examination score of 4 points below normal for his age and educational background. There was no personal or family history of depression or substance abuse. All routine and screening examinations were within normal limits.

Questions

1. The psychogeriatrician feels that the most clear diagnosis at this time is one of a mild cognitive disorder (MCI) or cognitive impairment not dementia (CIND); however, he strongly suspects that this case will progress to Alzheimer’s disease. What degree of information should be conveyed to the patient at this time?
2. If Mr. Green asks whether there are any specific medications that he should be considering at this time, what degree of further information would need to be conveyed concerning cognitive enhancement therapies?
3. How should questions of prognosis be addressed?

Discussion

Q1. The psychogeriatrician feels that the most clear diagnosis at this time is one of a mild cognitive disorder (MCI) or cognitive impairment not dementia (CIND); however, he strongly suspects that this case will progress to Alzheimer’s disease. What degree of information should be conveyed to the patient at this time?

At the present time, MCI (or CIND) is considered a diagnosis requiring further study and is not yet officially recognized. By definition, its associated deficits and impact upon everyday functioning are mild. Once reversible medical cases are ruled out, it is generally felt to be a progressive diagnosis with over 80% evolving to Alzheimer’s disease. Based on the presenting clinical history and the patient’s family history, the consultant geriatric
psychiatrist feels that in all likelihood it is highly probable that Mr. Green is demonstrating early signs of Alzheimer's disease, though a definitive diagnosis would be premature. This information has been conveyed to the family doctor by the consultant.

The family doctor knows Mr. Green well, having cared for the entire family for many years. Mr. Green spoke about his father's illness when he first entered the doctor's practice. When making the referral to the memory clinic, Mrs. Green expressed her concern about the probability of a diagnosis of Alzheimer's disease. Mr. Green also expressed his concern but added that his mind was clear and that he would not become a burden on his wife. When his doctor questioned him as to exactly what he meant, he was cryptic in his responses. The family doctor must now prepare to meet Mr. Green and his wife to review the consultant's report.

The core principles governing medical ethics are beneficence (doing the right or good thing), non-maleficence (doing no harm), autonomy (self-determination) and justice (fairness). The principle autonomy underlies the patient's right to self-determination and is embodied in the legal concept of consent, as well as in the Canadian Medical Association Code of Ethics with respect to responsibilities to the patient.¹

The doctor is now confronted with a patient who in all probability is in the earlier stages of Alzheimer's disease. His patient has clearly stated over many years that he would not live with this illness because of his concern for its impact upon others. His wife has made it clear that she would like the information withheld should the diagnosis of Alzheimer's disease be a possibility. At this time, the patient is clearly competent, and he has the right to receive full information concerning his condition.

The family doctor must now consider his various options for his meeting with Mr. and Mrs. Green. Key ethical principles include the patient's right to self-determination; however, both the family doctor and the patient's wife fear or have concerns that, in the face of such information, Mr. Green may attempt to end his life or harm himself. Mr. Green's fears need to be explored again despite his frequent proclamations in the past that he would kill himself if confronted with Alzheimer's disease. The passage of time and information about newer therapies may influence his thinking. The physician may also consider withholding information or strongly emphasizing the lower probability outcome that the memory difficulties may resolve. That option would be motivated by the desire to do no harm (non-maleficence) as a justification for the exercise of therapeutic privilege.

Q2. **If Mr. Green asks whether there are any specific medications that he should be considering at this time, what degree of further information would need to be conveyed concerning cognitive enhancement therapies?**

Mr. Green wonders if he should take vitamin supplements, change his diet or consider other treatments. The doctor feels that a trial of cholinesterase drugs could be clinically justified at this point in time. Many clinicians would likely concur. While such medications do not cure Alzheimer's disease, they do preserve functioning and seemingly slow progression. However, Alzheimer's disease is the only indication for these medications.

To obtain the patient's informed consent for a trial of this type of medication, it would be necessary to discuss the possible drugs available, as well as discussing side effects, dosing, how the drugs are thought to work and the reasons for which they are given. To provide erroneous information would be clear deception that might harm the therapeutic alliance between patient and doctor in the long term. Another approach might be to suggest simply that, in this clinical circumstance, a trial of this type of drug would be a good idea. The patient could be asked if he had any questions, and the doctor would have an opportunity to offer the truth or further information according to his assessment of the patient's wishes.

Many studies have shown that patients want to have as much information as possible when considering their condition regardless of the diagnosis, including the vast majority of individuals with Alzheimer's disease. The concern here is to weigh the possible benefit of discussing a cholinesterase inhibitor as an option to an individual with likely Alzheimer's disease versus limiting the discussion while waiting to see the clinical evolution.

Q3. **How should questions of prognosis be addressed?**

Prognosis is predicated upon diagnosis. There is a degree of clinical uncertainty in this scenario, but in all probability the diagnosis is one of Alzheimer's disease and this should dictate treatment. The doctor wishes to do no harm (non-maleficence) and wonders just how and what information to provide his patient. At every opportunity, the doctor should continue to explore the patient's thoughts about and plans for ending his life in the face of a definitive diagnosis of Alzheimer's disease. The patient's wife should be invited, with her husband's agreement, to participate in all of the discussions about possible and probable diagnoses and approaches to care.
Ultimately, the family doctor decides to tell the couple that the report from the memory clinic showed some deficits but that it would be premature to make any particular diagnosis. Simple aging without other disease could account for the current findings. The doctor tells the couple that he is concerned about Mr. Green's tendency to jump to conclusions but that good care here requires watchful waiting. He recognizes that he has weighted the interpretation of the clinical situation positively and knows that he must be vigilant with the couple to honestly let them know when or if the probability of Alzheimer's disease appears more likely. He feels he has given a version of the truth that will provide Mr. Green with time to reflect upon his options. He hopes he has taken the optimal approach and wonders what others might do.

**Canadian Medical Association Code of Ethics**

The Canadian Medical Association Code of Ethics has been prepared as a guideline for physicians in the practice of medicine. Its preface states that the code is "based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability." The first fundamental responsibility of the code states: "Consider first the well-being of the patient." Several items within the section "Communication, Decision Making and Consent" are relevant to the discussion of this case. They include the following articles:

21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.
24. Respect the right of a competent patient to accept or reject any medical care recommended.
27. Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment.
30. Be considerate of the patient's family and significant others and cooperate with them in the patient's interest.

**Therapeutic Privilege**

The concept of "therapeutic privilege" as mentioned above is the basis upon which a physician may decide to withhold information from a patient because of the belief that full disclosure may be harmful to the individual through the distress it may cause resulting in depression, despair, loss of hope or, in this case, the risk of suicide. Sometimes called "therapeutic exception," it has been viewed as an exception to the free and full disclosure of information necessary for informed consent. For many, the concept of "therapeutic privilege" is now seen as paternalistic and controversial, thereby providing little justification, if any, for applying it.

**References**


**Resources**

- Drane JF. Honesty in medicine: should doctors tell the truth? CIEB (Centro Interdisciplinario de Estudios en Bioética); 2002. Available from: [www.uchile.cl/bioetica/doc/honesty.htm](http://www.uchile.cl/bioetica/doc/honesty.htm)