Benevolent Lies: Fallible Universalism and the Quest for an International Standard

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In matters of morality the world of business is different from the world of medicine. In the world of business, the moral norm is universally that it is wrong to lie about one's product. Lies are told, but at least the moral standard is clear. Granted, one need not go out of one's way to tell the truth when one's product is deficient, but outright lying is immoral. In the world of medicine, the story is more complex. Not only are lies told in the practice of medicine; in traditional practice lying has not always been deemed morally wrong. In this sense, business people might be said to have a higher standard than medical professionals.

Medical practitioners have defended lying to patients and to research subjects. In widely diverse cultures doctors have lied, deceived, and withheld the truth from terminally ill patients.[1] Geneticists have hidden genetic diagnoses or told outright lies to patients when they have believed that patients were not mentally strong enough to hear the truth.[2] Pediatricians diagnosing ambiguous genitalia in babies have misinformed parents.[3] Physicians have prescribed placebos while telling patients with a straight face that the medication would cure their condition.[4]

Sometimes the lie extends beyond the patient-physician relation. Novack and his colleagues found in a study published in 1989 that almost 70 percent of American physicians would misreport the purpose of mammography to an insurance company in order to get the insurer to pay for the procedure.[5] Medical researchers have intentionally deceived subjects making them believe they were inflicting brutal torture on others in order to study the extent to which they will follow orders from authoritarian personalities.

The common feature in these medical lies (and the feature that sets physician lying apart from business lies) is that the motive is typically benevolent. This is not always the case. Doctors who have made errors that have directly harmed patients may refuse to disclose them to patients. These doctors may deceive themselves claiming that the purpose of the lie is to protect the patient from distress when the real

motive is to protect the physician.[6] Often, however, the true motivation of the lying doctor is benevolent. Novack found that almost all physicians gave benevolent reasons to justify their deception. Doctors do not want to produce anxiety in the dying patient; they don't want to produce self-fulfilling prophesies in those with genetic traits; they want to assure that their patients' medical expenses are covered by insurance; they want to produce important medical knowledge that can only be obtained by deception. When business people lie, that is not normally their purpose.

But does benevolence justify dishonesty and is there an international standard for answering that question? These are the two questions I want to bring before you today to open our international conference on "The Art of Telling."

Two Cases of Benevolent Lying

By dishonesty I refer to three related behaviors: telling outright lies, deception, and withholding the truth when one is in a relation in which truth is expected. Two examples set the stage for further deliberation. One is very recent and comes from Asia; the other is older and comes from Western culture.

Medicine in the Soup

Three medical practitioners from Hong Kong have described a case in the current issue of the *Journal of Medical Ethics* that is a perfect example of benevolent distortion of the truth. I would not for a minute suggest that cultural framework of Hong Kong can be transferred to Taiwan, but this case arises in a part of the world with similarities.

These practitioners are all associated with medical institutions in Hong Kong, have Asian names, and are apparently physicians. A 25-year-old man with a history of paranoid schizophrenia had demonstrated hostility to his mother and to health care providers. His mother, began covertly putting his antipsychotic medication in his soup. The result was noticeable therapeutic improvement. The psychiatrist, however, was morally perplexed by this strategy.

The authors of the article, the first of whom, Dr. Wong, happened to bear the same initial that was assigned to the psychiatrist in the case vignette, provide a classical Hippocratic moral analysis. They note the "benevolent deception," and points out that, if the strategy were disclosed:

> the relationships of trust between mother and son, and between doctor and patient would be likely to break down. The patient would resent being deceived in this way and would become angry and feel betrayed. His persecutory beliefs may become more fixed and he would probably develop an even more negative attitude toward mental health services....[7]

The authors conclude that "on balance the harm of truthful disclosure exceeds

[the] benefit."[8] For them, this makes the deception morally justified. Like good Hippocratic consequentialist physicians, they assume that the benefit/harm calculation settles matters of morality. They point out along the way that disclosure would be "respectful of [the patient's] autonomy," but still conclude that "the benefits of disclosure are not very compelling."[9]

I hesitate in attributing their conclusion to Hippocratic paternalism because the authors go to some length to relate their analysis to Chinese culture claiming that in this setting "the notion of respect of an individual's right to self-determination is a weak notion due to the Confucian concept of social personhood."[10] They point out that in Chinese cultures family input in treatment decisions is the norm. One is left with the sense that the authors make the often-heard claim that matters of ethics, especially matters of honesty, are culturally relative. In Chinese culture, the pattern of respect for the family justifies the continued cooperation of the psychiatrist with the mother in serving the interest of the patient.

The Conspiracy of Silence

Compare this to a case in which I was involved in the early 1970s when I was the program director of the medical ethics program at Columbia University's College of Physician and Surgeons. On our hospital floor a 14-year-old boy was dying of leukemia. He was not expected to leave the hospital. He had never been told of his diagnosis and prognosis. In order to maintain the fiction, his parents, who were apparently in on the rouse, arranged for the school system to send a personal tutor to the hospital daily to help the boy with his school work. In order to maintain his hope, they continually spoke of his returning to school. That, in turn, required doing what one would do with a patient who was expected to recover–including getting the school to pay for the tutor.

This arrangement continued for some days until the boy learned of his fate by overhearing two residents talking outside his room. They were not in on the "treatment plan" that included dishonestly conveying hope for recovery. The boy was devastated. Moreover, for some time no one else knew that he knew so no one was able to intervene with support for what must have been an unbearably traumatic and lonely experience.

Moral Foundations of Veracity

The terrible outcome of this case suggests the reason many American physicians have dramatically changed their views on the ethics of truth-telling. A pair of empirical studies tells the story. In 1961, physician Donald Oken published a study based on interviews with 219 university-based physicians.[11] When asked about disclosure of a confirmed diagnosis of cancer, 88 percent indicated that it was their usual policy not to tell the patient. This is a pattern not unlike that found in many surveys in Asian settings. By 1979, however, a team headed by David Novack

repeated the study and found that, by then, 97% of physicians preferred telling in such cases.[12] Cases such as that of the boy who accidentally learned of his impending death are sometimes sited as the basis for the change.

The Utilitarian Analysis

The earlier pattern of American physicians almost universally inclined to deceive is strikingly similar to the Asian pattern described by the psychiatrist who defends the medicine in the soup. There was an important difference, however. The Asian physicians could defend their decision by appealing to something they called "Chinese culture." They could make a case that Chinese lay people agreed in giving the family the critical role in deciding about deceiving the patient. There is substantial support for the thesis that various cultures throughout Asia support more indirect and family-based approaches to deciding what to tell a patient.[13] Some have recently suggested that, true to its ambivalent position in the world, Hong Kong lies somewhere between Chinese familial orientation and American individualism,[14] but most analyses, at least until recently, have echoed the theme that Asian cultures vest the family and the physician with considerable authority to determine the pattern of truthful communication with the patient.

By contrast the society of American lay people has long disagreed with the paternalism of its physicians.[15] In the 1950s surveys reported that 80-90 percent of patients stated that they would want to be told of a cancer diagnosis.[16] Moreover, when patients were asked who had cancer, the response in favor of disclosure was even higher. Highest of all was the response of patients awaiting a cancer diagnosis.[17]

Not only have patients supported honesty with patients; hints of that attitude among leading physicians have appeared as well. The eighteenth century Scottish father of Anglo-American medical ethics, John Gregory, was staunchly in the camp of the paternalists,[18] but his successor, Thomas Percival, began adopting a more ambivalent stance on truth-telling,[19] and by the middle of the nineteenth century, Connecticut physician, Worthington Hooker, was militantly in favor of truth-telling.[20] So was early twentieth century medical scholar, Richard Cabot.[21]

These stances of American physicians on truth-telling, whether pro or con, were grounded almost exclusively on consequence-based reasoning strikingly similar to that of Wong and his colleagues–the Hong Kong practitioners. Hence the range of views among American physicians on the subject parallels that of Western utilitarian philosophers and theologians. One of the most famous of all, the British philosopher Henry Sidgwick, in his classic utilitarian defense of deception, argues that "where deception is designed to benefit the person deceived, Common Sense seems to concede that it may sometimes be right."[22] On the other hand, situationalist utilitarian, Joseph Fletcher, rigidly opposes the harmful consequences of dishonesty.[23]

He would point to the horrors of deceiving the school boy with leukemia.

Thus Western consequentialists have demonstrated ambiguity regarding the ethics of lying to patients and deceiving them, especially about communicating terminal diagnoses. Both physicians and lay people have acknowledged the potential harms of revealing an honest prognosis, especially if it is done carelessly. On the other hand, more sophisticated physicians (such as Hooker and Cabot) as well as lay consequentialists have emphasized the terrible consequences of a conspiracy to deceive.

Moving Beyond Consequentialism

The consequentialist approach that has dominated physician ethics has led many clinicians to oppose any firm moral rules governing what to tell patients. Both the earlier Oken study and the more recent Novack survey showed that almost all physicians reject firm, rule-like approaches that restrict clinician flexibility. This has led professional medical ethics to resemble a kind of moral relativism in which the judgment about what to tell patients is fine-tuned to the individual situation. In this they agree with philosophers and other medical lay people who are, in effect, act utilitarians. They decide what to disclose to patients based on their calculation of the consequences in the individual situation. Thus traditional Hippocratic ethics has much in common with other relativist analyses that point to the wide range of cultural practices in different cultures.[24] The only special and morally controversial feature of physician ethics is that it tends to limit the relevant consequences to those affecting only the patient. Hence, patients are told the truth or lied to based on the clinician's calculation of the impact on the patient.

This professional ethic is controversial on three grounds. First, it introduces the risk of bias and error from the idiosyncratic views of the consequences as seen by the individual practitioner. Since physicians are known to have unique psychological mindsets, this means their judgments about the consequences for the patient may be different from how others. For example, in the 1960s it was shown that American physicians have uniquely high fear of death and presumably this would be factored into their judgment of the effect on patients of being told of a terminal diagnosis.[25] It is reasonable to assume that in Asia as well people choose medicine as a career because they have unique psychological needs to fight death.

Second, traditional Western physician views about honesty in communication with patients will be shaped by their exclusion of the consequences to others in the calculations of benefits and harms. This might not be as much of a factor in a culture influenced by the more social and familial orientation arising from Confucian influence, but in the West it means that physicians are put in an uncomfortable position when they are asked to lie to patients for research purposes. On the other hand, they easily accept lying to insurance companies to benefit their patients.

Third, and most critically, physician ethics stands in conflict with deontological and other non-Hippocratic ethical systems. Some are rule utilitarians who base their judgments on the consequences of alternative sets of rules but resist fine-tuning bedside judgments based on individualized assessments of consequences. Others look to a normative ethic that refuses to base right and wrong on consequences. They go beyond benefit and harm. They would, for example claim that Dr. Wong's patient-best-interest argument does not settle the matter morally. They are open to the possibility that it could be immoral for a physician or a mother to intentionally deceive a patient even if doing so turns out to be in the patient's best interest. Some quality may make the lying or deceit wrong even if it is utility maximizing. It could be wrong because it shows lack of respect for persons or, more specifically, because it violates a moral principle of veracity–the idea that it is simply wrong to tell a lie or to deceive when one is in a fiduciary relationship in which communication that is not misleading is the expectation. It could be wrong even in the face of empirical anthropological evidence showing a range of different practices throughout different cultures. The moral question is not an empirical one of whether cultures differ in fact. The question reasonable people free from the distorting constraints of cultural bias would differ.

Is There an International Standard?

This opens the possibility that there are international moral standards about truth-telling in the medical context–standards that cannot be resolved by appeal merely to the practices of a local culture or what will produce good consequences for the patient. Both these criteria would presumably incorporate the unique social and psychological features of a culture.

Recently, there is emerging evidence that Asians are having second thoughts about the thesis that their culture gives priority to humaneness (or jen) expressed as avoidance of direct communication of bad news to patients. As Asian scholars interact with Western culture and Westerners absorb more Eastern perspectives, analysts are finding more evidence of respect for the autonomy and more emphasis on honest disclosure. These scholars–Nie, Tsai, and Fan, in particular[26]–are finding a complex mix of traditional Confucian and more individualistic concerns in the Asian ethics of truth-telling and consent. Or, perhaps more carefully put, they are finding that Confucian thought has room for some of these perspectives more generally associated with Western individualism. Undoubtedly, in both East and West individual patients reflect a spectrum of moral views on the subject. It is now clear, however, that it is too simple to claim that the West is all autonomy and the East has none.

The ethics of truth-telling is not merely a matter of culturally determined socially constructed fine-tuning of judgments. The claim is being made that an

international standard–a universal frame of reference–exists for deciding when, if ever, it is morally acceptable to lie or withhold the truth. For those adopting this perspective, the critical question is what that universal standard might be.

Medical Professional Standards

Those doing ethics in a medical context, especially physicians, sometimes claim that ethical standards for the practice of medicine can be derived from moral requirements logically entailed in the concept of medicine. In Edmund Pellegrino's terms, there is a universal standard "internal" to medicine.[27] They may be impressed, for example, by the American Medical Association's dramatic reversal in 1980 on the subject of physician honesty. After decades of acceptance of the benevolent lying to patients, the AMA in that year adopted a principle including a flat prohibition on lying. According to the AMA, "A physician shall deal honestly with patients and colleagues."[28]

This bold, apparently exceptionless commitment to honesty is a substantial departure from the earlier ethical codes articulated by medical professional groups. But that presents a problem for those seeking a timeless international standard. While the AMA appears to claim that it has a basis for knowing the moral standard for physician conduct–unlimited by circumstances of time, place, or patient situation–their view differs from other professionally articulated standards. It differs from earlier American codes. It differs from international codes such as those of the World Medical Association or the original Hippocratic Oath, neither of which make any explicit commitment to physician honesty. In fact the Hippocratic Oath's strong commitment to having the physician do what he considers best for the patient implicitly endorses benevolent lies–when necessary to benefit the patient.

The real problem with professionally articulated codes as a basis for establishing an international standard is that medical professional groups have no unique epistemological authority for determining the norms of conduct for physicians. There is no reason for lay persons to cede authority to a medical professional group for deciding the moral standards for the relationship between doctor and patient. The patient is a moral agent with as much ethical authority as the physician. A medical professional organization is a group whose organizing principle is that it is limited to only one of the two parties in the patient/physician relation. The members of a profession possess no basis for authoritatively establishing universal norms for when doctors should tell the truth. Hence, even if a national could unanimously agree on the standard for truth-telling, the group is doubly inadequate for claiming authority. It is not an international group and it is not metaethically authoritative for medical lay people. If there is to be an international standard it will have to come from some more authoritative source.

Universal Standards for Morality: More Plausible Candidates

The moral theories of the philosophers and theologians may provide an answer. By appeal to reason, natural law, a set of ethical principles or a common morality, these theories claim to be able to locate a universal grounding for medical morality (including a morality for truth-telling).

Kant: Appeal to Reason

For Westerners at least, the German philosopher, Immanuel Kant, provides an approach that claims a universal standard. That standard is reason. Kant claims that the maxim prohibiting lying is required by reason. Since reason is a feature shared by all humanity, it provides a universal basis for judging lies and deceptions as immoral. Reason tells him (and arguably the rest of us) that one cannot simultaneously will to follow a maxim permitting lies and at the same time universalize that maxim so that it applies to everyone in a similar situation. To do so would be logically self-defeating and therefore to accept such a maxim would be illogical. In his famous essay "On the Supposed Right to Lie for Benevolent Motive," he puts the matter quite bluntly: "To be truthful (honest) in all declarations, therefore, is a sacred and absolutely commanding decree of reason, limited by no expediency,"[29] that is by no good consequences.

Natural Law

Alternatively, one might turn to more empirical approaches to find an international or universal standard for the duty to tell the truth. In the West both secular and religious sources have claimed morality is grounded in a set of moral laws of nature that apply to all members of the human species. These laws are expressed in the ten commandments of Judaism, including one which prohibits bearing false witness. More generally, natural law theory often finds lying and deceitful withholding of the truth in relationships where truth is expected to violate norms purported to be universal.

Principlist and Rights-Based Approaches

A third basis for claiming a universal standard for an ethic of truth-telling is found in the recent development of principle-based approaches that are particularly prominent in biomedical ethics.[30] These approaches, which are now being used throughout the world,[31] ground the duty to truthfulness in the notion of respect for persons. Defenders of principle-based ethics give particular attention to cases in which a principle of beneficence supports benevolent lying. They claim that, even when beneficence might support lying, a principled reason exists to deal honestly with patients.

Sometimes these principle-based ethicists derive a duty of truthfulness from a more general principle of autonomy.[32] Often they connect this duty with their consent doctrine. Informed consent is impossible, they argue, if the patient is misinformed.[33] Patients would not rationally consent to chemotherapy unless they

had reason to believe they had cancer. They cannot consent to research if the research design includes deception.

Other versions of principle-based approaches explicate the notion of respect for persons claiming it incorporates several more specific principles including fidelity and veracity as well as autonomy.[34] One reason for drawing a truth-telling principle explicitly out of the notion of respect for persons is that it makes clear that the truth is owed even to persons who are not substantially autonomous.

Common Morality

While these foundations for a universal obligation of honesty contain subtle differences, they share the common feature of claiming that truthfulness is not merely a matter of producing good consequences for the patient or conforming to culturally-specific preferences. They claim that there are a few general moral requirements that are agreed to by all (or almost all) reasonable people regardless of culture. Since the claim is widely shared among different versions of universalist theory, it has recently been referred to as the "common morality" thesis.[35] Regardless of whether the general features of morality are articulated as requirements of reason, universal natural laws, ethical principles, or moral rules, defenders of these ethics agree that there is a morality common to reasonable people universally. This is accepted even by some theorists who reject more specific principlist or natural law approaches.[36]

The great challenge for common morality theorists is whether these claims can be supported by non-Western ethical systems.[37] The common morality people claim that they do, but evidence for support, for example from Chinese theorists, remains to be demonstrated.

At its worst, the common morality thesis could be seen as an imperialistic effort to impose mainstream Western moral views on truth-telling and other core moral notions onto the populations that did not share a common origin. The debate is thus joined between the universalists who claim that there is a commonly shared moral framework for all humans regardless of culture and the relativists who challenge the arrogance and authoritarianism of those claiming a common morality.

Either approach risks serious offense. The relativists risk having to condone oppression of low-status groups–women, ethnic minorities, and (in medicine) patients because there is no leverage for international challenge of local practices that engage in this oppression. On the other hand, universalists risk riding roughshod over minorities and out-groups who deserve respect. Thus the claim that there is a universal duty of truthfulness poses risks as does its opposite claim that what counts as acceptable communication with patients is a matter of local standards and tastes.

A More Subtle View: Universal Morality and Human Fallibility

I propose that there is an intermediate position that must be defended on

matters of truth-telling and other matters of medical morality. It is a policy of toleration without lapsing into moral relativism. It affirms a belief in a universal standard without implying that humans have the power to impose that standard in all cases.

On some issues behavior that looks like relativism will prevail; on others a universal standard must not only exist, but must be the basis for imposing international moral authority to reverse local behaviors that are intolerable. The strategy I propose is the affirmation of the common morality view combined with a robust acknowledgment of human fallibility.

An ethic of universal standards combined with admission of human fallibility will often have the look of an ethic that is morally relativist, but it will deny the relativists main claim: that morality is nothing more than an expression of the moral consensus of a particular cultural group. It shares with Catholic natural law doctrine and Kantian ethics the belief that morality really is subject to universal standards. Lying to the schizophrenic about what is in his soup really is morally right or wrong. So is lying to the dying adolescent with leukemia. These are not mere matters of local style.

At the same time my proposal acknowledges that humans are fallible beings. Fallible humans can never know with certainty what the universal standard of morality dictates for the soup or the uninformed adolescent. That will mean that some (but not all) behaviors that fail to conform to the universal standard will have to be tolerated. Respect for persons requires in many cases showing toleration for those with different reads of the universal standard. The result ends up looking rather like moral relativism, but in fact preserves the belief in universalism. Both the stern critic of the Hong Kong physician's paternalism and the defender will stand firm in their belief that they are advocating behavior that is right or wrong. They must, however, simultaneously concede that from their finite human perspective they may have it wrong. Let's call this the morality of "fallible universalism."

At the same time, fallible universalism must sometimes encounter cases in which human fallibility is not sufficient to constrain claims that some moral behavior is wrong and must change. Policies that are racist, that oppress women, that impose slavery, or use a population as involuntary research subjects cannot simply be excused on the grounds that their critics are fallible. It is no more acceptable to rely on fallibility to tolerate these than it is to rely on the position of moral relativism. There are some behaviors that are not only a violation of the common morality, but are clearly such severe violations that they cannot be tolerated. The grand task is to draw the line between immoral behaviors that can out of humble fallibility can be tolerated and those that are so different from matters of taste that they must be combatted.

A Movement Toward Convergence on Truth-telling

I suggest that local customs regarding truth-telling are often matters of morality–not mere matters of local preference. Some lies to the dying really are wrong–so it seems to me. Some bluntly truthful statements may also be immoral. That, I suggest, is not the crucial issue. What is crucial is distinguishing between those behaviors that, though classified as immoral, should nevertheless be tolerated and those that are immoral and simultaneously are intolerable.

I suggest that both the donation and the routine salvaging models for cadaveric organ procurement are both morally tolerable–even if only one is really the morally right course. I suggest that both national bans on therapeutic cloning and national condoning are morally tolerable–even if only one is really the morally right course. I suggest that some tolerance of lying and some policies condemning it are tolerable as well. In closing let me set out some ways of distinguishing tolerable from intolerable lying and deception.

(1) **The right to consent to being deceived**. First, even the most rigorous defenders of truth-telling must concede that substantially autonomous persons should have the right to waive their right to truthfulness. They should be able to authorize their family or their physician to intentionally deceive them, withhold the truth from them, or even tell outright lies to them.[38] They have the right to consent to being dealt with untruthfully. I am not willing to concede this is the morally right thing to do, but surely it is morally tolerable. There is no necessary moral imperative to tell the truth when one has waived the right to it.

All of us will waive our right to trivial information when gaining that information would be too time consuming or boring. We probably also will waive it when a debilitated condition would make the truth too onerous. We have a right to consent to a randomized clinical trial in which a placebo arm will be included. Even if it might not be a noble life to lead, we also have the right to waive knowledge of terminal diagnosis provided we understand what we are doing.

(2) **Lies/Deception/and Withholding the Truth from Incompetent Persons** Second, cultures differ so significantly on how they treat their incompetent members that we should tolerate a wide range of policies authorizing parents and other valid surrogates to withhold truth from their incompetent wards and perhaps even to tell certain lies to them. My culture propagates the falsehood that a fat, old man with a white beard drives a slay around the world on Christmas eve and delivers presents to children who have been good. I never once imposed that lie on my children, but I admit I did not always forcefully disabuse them of their belief that they had absorbed from dishonest people. If parents consent to untruthful behavior regarding medical treatment of their children, I believe that should be tolerated. I am not claiming it is moral, but it is tolerable. After all, we who advocate of truth may be wrong.

(3) Community authorization of Dishonesty

The most difficult case for those who would tolerate cultural differences on grounds that knowledge of universal standards is fallible is the claim of some cultures that the community as a group has the authority to approve of patterns of benevolent dishonesty. Sometimes these will be defended on the ground that the community implicitly agrees to (consents to) these arrangements.[39]

This so-called community authorization for withholding the blunt truth is a difficult case because it is hard to determine the extent to which individuals in the community concur with the deceptive practice. To the extent that they do, this is nothing more than a special case of individuals consenting to dishonesty. It seems clear, however, that some members of the community may have no opportunity to consent. Wives and members of religious and intellectual minorities may not have consented to the practice of benevolent lies. Believers in the principle of veracity should have a problem with such practices. At minimum, members of the culture who are unwilling to accept the practice–those with international experience, ex-patriots, and those who simply don't concur with the community–should have the right to dissent and get information necessary to show respect for persons. That includes any information necessary for them to give informed consent to medical treatments. If patients agree with cultural practices that condone less direct methods of communication, their agreement should be respected, but if they want to be dealt with honestly, they should have that right. That, at least, is where a Western, autonomy-oriented defender of fallible universalism has to draw the line.

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