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# Report of the American Medical Association Council on Ethical and Judicial Affairs: Withholding Information from Patients: Rethinking the Propriety of "Therapeutic Privilege"

*Nathan A. Bostick, Robert Sade, John W. McMahon,  
and Regina Benjamin*

**Nathan A. Bostick, MA, MPP**, is a Senior Research Assistant at the American Medical Association Ethics Group in Chicago, [Andy.Bostick@ama-assn.org](mailto:Andy.Bostick@ama-assn.org).

**Robert Sade, MD**, is a Professor of Surgery at the Medical University of South Carolina in Charleston.

**John W. McMahon, MD**, is Corporate Medical Director of the Montana-Pacific Quality Health Foundation in Great Falls, Montana.

**Regina Benjamin, MD, MBA**, is Chief Executive Officer of the Bayou La Batre Rural Health Clinic in Bayou La Batre, Alabama. © 2006 by *The Journal of Clinical Ethics*. All rights reserved.

## INTRODUCTION

Some physicians have withheld medical information from patients when they have believed full disclosure to be medically contraindicated, to avoid potential harm to the patient's physical or psychological well-being. This practice, commonly referred to as "therapeutic privilege," is distinct from circumstances when it is not feasible to disclose information to a patient, such as emergency situations or other instances when a patient lacks the capacity of making decisions.<sup>1</sup> It also is distinct from disclosure issues that arise from medical errors, which the American Medical Association Council on Ethical and Judicial Affairs (CEJA) has addressed in a previous report.<sup>2</sup>

Intentionally withholding information may be viewed as presenting a conflict between a physician's ethical imperative to protect patients and a physician's ethical obligation to be truthful and to provide patients with relevant medical information. Moreover, it abrogates the process of shared decision making and conflicts with contemporary expectations that physicians will respect patients' autonomy and enable them to take an active role in making treatment decisions that reflect their interests and preferences. It is in this context that this report re-examines the ethical propriety of withholding medical information from patients.

## ETHICAL ANALYSIS

Nondisclosure of medical information was once uncontroversial, when paternalism afforded physicians broad discretion in making treatment decisions on behalf of their patients. Stemming from the Hippocratic tradition, physicians were ethically obligated to promote their patients' welfare by providing care in accordance with their own judgment regarding the most appropriate course of treatment.<sup>3</sup> Physicians could opt not to share potentially distressing diagnostic or prognostic medical information with patients if they believed that disclosure might prove detrimental to patients' well-being.<sup>4</sup> Accordingly, the selective withholding of medical information could be viewed as fulfilling physicians' obligations both to act beneficently<sup>5</sup> and to promote patients' overall well-being.<sup>6</sup>

This practice of nondisclosure was well established in the foundational works of Western medical ethics, such as Percival's *Medical Ethics*, which promoted the beneficent withholding of medical information to minimize patients' distress.<sup>7</sup> Similarly, the 1847 American Medical Association (AMA) *Code of Medical Ethics* stated that physicians had a "sacred duty . . . to avoid all things which have a tendency to discourage the patient and depress his spirits."<sup>8</sup> These guidelines helped to establish legal precedents that allowed physicians to withhold potentially harmful information from their patients, in the event that full disclosure would impede patients' abilities to render rational decisions or harm them in other ways.<sup>9</sup>

In recent decades, medical paternalism has given way to the contemporary concepts of patient autonomy and shared decision making.<sup>10</sup> Today, physicians are called upon to promote patients' well-being by openly discussing the balance between anticipated benefits of a given intervention and its potential harms.<sup>11</sup> In some instances, a case-specific balance of benefits and harms may appear to some physicians as justification to withhold medical information, with the beneficent desire to protect patients from potential harms. However, a physician's concealment of medical information may not prove beneficent if it contravenes a patient's own wishes.

Many patients want detailed medical information, even if it means receiving adverse diagnostic or prognostic information.<sup>12</sup> Physicians' communication of detailed medical information has been shown to ease patients' anxiety and improve health outcomes.<sup>13</sup> Moreover, increased levels of communication and sharing of information may also contribute to higher levels of patients' satisfaction<sup>14</sup> and potentially decrease malpractice liability.<sup>15</sup> Conversely, the lack of adequate information may preclude patients from receiving necessary medical attention or making optimal life decisions on the basis of their individual needs and personal values.<sup>16</sup>

Withholding pertinent medical information from patients without their knowledge or consent may also have negative long-term consequences for the medical profession. The patient-physician relationship is founded upon trust, because patients must rely upon their physicians to provide the information needed to make a properly informed decision.<sup>17</sup> Lack of candid disclosure can compromise this relationship if patients suspect (or later discover) that information is being withheld from them.<sup>18</sup> Thus, individual physicians' purportedly benevolent acts of deception risk undermining not only individuals, but also public confidence and trust in the medical profession.<sup>19</sup>

In practice, medical information should never be permanently withheld from the patient because doing so represents a clear violation of patients' trust. However, physicians' obligation of beneficence may allow (or compel) them to postpone the full disclosure of information to patients whose capacity to make competent medical decisions may be compromised, or when disclosure is otherwise medically contraindicated.<sup>20</sup> Delayed disclosure, however, is not justified when physicians merely intend to prevent a patient's refusal of medically necessary treatments,<sup>21</sup> or to instill hope for the future.<sup>22</sup>

Little is known of the extent to which disclosure of alarming medical information may ultimately harm patients.<sup>23</sup> Physicians are encouraged to consult colleagues or hospital ethics committees when considering the need to temporarily withhold medical information from their patients. Such consultations reflect respect for patients' right of self-determination and can be of real help to physicians in assessing available alternatives to postponement of communicating medical information.

When physicians determine that a patient should not receive all relevant medical information at a given time, they need to continue to provide appropriate care for and monitor the patient to identify an appropriate time to offer full disclosure. This should be done according to a definite plan, so that disclosure is not permanently withheld.

## **PROMOTING PATIENT-PHYSICIAN COMMUNICATION**

Physicians' concerns about disclosure of potentially harmful information should lead them to encourage patients to make choices regarding the receipt of medical information before potentially harmful information becomes available.<sup>24</sup> Physicians should tailor their disclosure of medical information in response to the needs, expectations, and preferences of individual patients.<sup>25</sup>

To respect patients' rights of decisional autonomy, physicians must offer all patients the opportunity to receive relevant medical information.<sup>26</sup> This may be accomplished by asking patients to specify the scope of information they wish to receive and their preferred methods for receiving it. Physicians should then honor these preferences to the extent practicable.

Some patients may want certain medical information to be withheld.<sup>27</sup> Others may wish to involve family members in the decision-making process or, alternatively, to appoint family members or trusted caregivers to act as their proxy.<sup>28</sup> Physicians should respect the wishes of competent patients, including accommodation of their cultural and religious beliefs.<sup>29</sup> However, physicians should consider patients' decisions sensitively to ensure that their requests are not coerced and genuinely represent the patients' preferences.<sup>30</sup> Additionally, physicians should educate patients and their proxies about the importance of disclosure and shared decision making.<sup>31</sup>

When communicating medical information, physicians should assess the amount of information that patients want and are capable of receiving at a given time.<sup>32</sup> Clinical judgment is required to determine the appropriate means for communicating relevant information, taking patients' personalities and clinical histories into account when possible.<sup>33</sup> Information should be presented in a way that patients can understand and use in making medical decisions.<sup>34</sup> Finally, physicians should attempt to confirm that this information has been understood — for example, by asking them to repeat what they have been told — and providing further clarification as necessary.<sup>35</sup>

Physicians should communicate all requested medical information sensitively and respectfully,<sup>36</sup> while seeking to minimize any negative effects upon the patient.<sup>37</sup> By listening to patients' concerns and responding to their individual need, physicians can promote the patient-physician relationship<sup>38</sup> and protect against the iatrogenic suffering of patients.<sup>39</sup> Physicians can also minimize potential harms by monitoring patients' well-being and by helping them to access appropriate support services, when needed.<sup>40</sup>

## **CONCLUSION**

Withholding relevant medical information from patients without their knowledge or consent, in an attempt to minimize potential physical or psychological harms, has been called "therapeutic privilege." This practice creates a conflict between physicians' concurrent obligations to act beneficently and to respect patients' autonomy. Whenever possible, physicians should minimize the withholding of medical information by accommodating patients' preferences.

## **RECOMMENDATIONS**

Withholding pertinent medical information from patients under the belief that disclosure is medically contraindicated, a practice known as "therapeutic privilege," creates a conflict between the physician's obligations to promote patients' welfare and respect for their autonomy by communicating truthfully. Therapeutic privilege does not encompass

withholding medical information in emergency situations, or reporting medical errors (see E-8.08, "Informed Consent," and E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm").

Withholding medical information from patients without their knowledge or consent is ethically unacceptable. Physicians should encourage patients to specify their preferences regarding communication of their medical information, preferably before the information becomes available. Moreover, physicians should honor patient requests not to be informed of certain medical information or to convey the information to a designated proxy, provided these requests appear to genuinely represent the patient's own wishes.

All information need not be communicated to the patient immediately or all at once; physicians should assess the amount of information a patient is capable of receiving at a given time, delaying the remainder to a later, more suitable time, and should tailor disclosure to meet patients' needs and expectations in light of their preferences.

Physicians may consider delaying disclosure only if early communication is clearly contraindicated. Physicians should continue to monitor the patient carefully and offer complete disclosure when the patient is able to decide whether or not to receive this information. This should be done according to a definite plan, so that disclosure is not permanently delayed. Consultation with patients' families, colleagues, or an ethics committee may help in assessing the balance of benefits and harms associated with delayed disclosure. In all circumstances, physicians should communicate with patients sensitively and respectfully.

## NOTES

CEJA formulates ethical policies for the medical profession and maintains the 160-year-old *American Medical Association Code of Medical Ethics*. This article is based on the CEJA policy report, "Withholding Information from Patients," which was approved by the AMA House of Delegates in June 2006. The recommendations of this report are now included among the official ethics policies of the American Medical Association.

1. CEJA Opinions E-8.08, "Informed Consent" and E-8.081, "Surrogate Decision Making," <http://www.ama-assn.org/go/cejareports>, or call (312) 464-4823.

2. CEJA Opinion E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm," <http://www.ama-assn.org/go/cejareports>, or call (312) 464-4823.

3. A. Meisel, "The 'Exceptions' to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decision Making," *Wisconsin Law Review* (1979): 413-88, p. 460, n. 153.

4. D. Novack et al., "Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems," *Journal of the American Medical Association* 261, no. 20 (1989): 2980-5.

5. *Ibid.*

6. B. Barber, *Informed Consent to Medical Therapy and Research* (New Brunswick, N.J.: Rutgers University Press, 1980), 37.

7. P.R. Wolpe, "The Triumph of Autonomy in American Bioethics: A Sociological View," in *Bioethics and Society*, ed. R. Devries and J. Subedi (Upper Saddle River, N.J.: Prentice Hall, 1998), 39.

8. R. Boyle, "Communication, Truth-telling, and Disclosure," in *Introduction to Clinical Ethics*, 2nd ed., ed. J. Fletcher et al. (Hagerstown, Md.: University Publishing Group, 1997), 56-7.

9. 464 F.2e 772 (D.C. Cir 1972); *Natanson v. Kline*, 350 P.2d 1903 (Kan. 1960).

10. CEJA Opinion E-8.08, "Informed Consent," see note 1 above.

11. CEJA Opinion E-10.015, "The Patient-Physician Relationship," <http://www.ama-assn.org/go/cejareports>, or call (312) 464-4823.

12. M. Marzanski, "Would You Like to Know What is Wrong with You? On Telling the Truth to Patients with Dementia," *Journal of Medical Ethics* 26 (2000): 108-13; M. Silverstein et al., "ALS and Life-Sustaining Therapy: Patients' Desires for Information, Participation in Decision-Making, and Life-Sustaining Therapy," *Mayo Clinic Proceedings* 66 (1991): 906-13.

13. See note 8 above.

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16. P. Herbert et al., "Bioethics for Physicians: 7. Truth Telling," *Canadian Medical Association Journal* 156, no. 2 (1997): 225-8; J. Weeks et al., "Relationship between Cancer Patients' Predictions or Prognosis and Their Treatment Preferences," *Journal of the American Medical Association* 279, no. 21 (1998): 1709-14.

17. CEJA Opinion E-10.01, "Fundamental Elements of the Patient-Physician Relationship," <http://www.ama-assn.org/go/cejareports>, or call (312) 464-4823.

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21. M. Wynia, "Invoking Therapeutic Privilege," *AMA Virtual Mentor*, accessible at <http://www.ama-assn.org/ama/pub/category/print/11937.html>.

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29. E. Etchells et al., "Bioethics for Clinicians: 2. Disclosure," *Canadian Medical Association Journal* 155 (1996): 387-91.

30. See Herbert et al., note 16 above.

31. *Ibid.*

32. British Medical Association, *Human Genetics, Choice and Responsibility* (Oxford: Oxford University Press, 1998), 86-8.

33. See note 4 above.

34. See Herbert et al., note 16 above.

35. D. Schillinger et al., "Closing the Loop: Physician Communication with Diabetic Patients Who Have Low Health Literacy," *Archives of Internal Medicine* 163, no. 1 (2003): 83-90; National Quality Forum, *Implementing a National Voluntary Consensus Standard for Informed Consent: A User's Guide for Healthcare Professionals* (Washington, D.C.: National Quality Forum, 2005).

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37. G. Weiss, "Patients' Rights: Who Should Know What?" *Medical Economics* 19 (2002): 97.

38. See note 23 above, p. 11.

39. Da Silvia et al., "Not Telling the Truth in the Patient-Physician Relationship," *Bioethics* 17 (2003): 417-24.

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