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The End of Therapeutic Privilege?

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Truth-telling and good communication are essential components of a trusting (and trustworthy) doctor-patient relationship. The AMA guidelines, "Withholding Information From Patients: Rethinking the Propriety of 'Therapeutic Privilege'," provide clear and thoughtful justification for disclosing health information to patients. These new AMA guidelines sharply narrow "therapeutic privilege," defined as the practice of withholding information from patients when disclosure is deemed to be medically contraindicated or to avoid potential physical or psychological harm to the patient. If MDs withhold health information from patients, they need to provide a convincing justification. This is a stark change from the historical practice that a physician's duty included the beneficent withholding of information for the sake of the patient. The presumption now in the AMA guidelines is "to offer all patients the opportunity to receive relevant medical information." Medical information should never be permanently withheld from a patient, although there are situations when postponement or a step-wise approach to disclosure may be more appropriate. In addition, the guidelines suggest that patient-physician communication can be enhanced by asking patients how much information they would like and how it should be delivered. This approach allows the physician to respect the wishes of the patient concerning withholding information. Although the recommendations are clear, physicians still need more specific guidance. What harm or "medical contraindication" would justify withholding information? To date, most discussions have concerned withholding the diagnosis of cancer from a patient from a cultural background where such diagnoses are not usually disclosed.[1] The following two cases illustrate additional dilemmas regarding disclosure and suggest how to resolve the practical issues that physicians face when implementing the AMA guidelines. Physicians may find it useful to organize their approach around a series of questions (see table 1): Whether to disclose? Who should disclose? When to disclose? Where to disclose? What to say to the patient?

THE PATIENTS

CASE 1

Ms E. is a 67-year-old African-American woman brought in by ambulance to the emergency department (ED) at a busy public hospital after a bus accident. She was found to have a dislocated shoulder, which was reduced. Because the patient also reported vague abdominal pain, a CT [computed tomography] scan of the abdomen and pelvis was ob-

tained. The scan revealed no evidence of trauma, but diffuse masses consistent with metastatic disease were seen.

Ms E. was terrified and repeated, "I'm in pain, I'm in pain." She had trouble answering questions because of her distress. The ED staff became frustrated and felt she needed to cooperate more with the history taking. After receiving opioids for pain, Ms E. remained agitated. She was given promethazine. She then became drowsy and slightly confused.

Because Ms E. was brought into the ED as a trauma patient, she was placed in one of the trauma bays, which had bright lights, deafening noise, and many people coming in and out. She repeatedly asked for her belongings and stated that she did not feel secure. A physician who was involved with her care from the beginning decided to tell Ms E. the results of the CT scan. Asking further information about Ms E.'s medical history, the doctor learned that Ms E. had been diagnosed with breast cancer 10 years ago. The physician started by saying, "I have something to tell you about your CT scan. There is no sign of injury from the accident, but I am afraid there were multiple spots seen on the scan. I think this might be cancer." Ms E. was appropriately stunned by this information. She stated that she would stay to have this further evaluated.

A few hours later, after the physician who told her this information finished her shift, Ms E. left the emergency room against medical advice.

CASE 2

Mr. G. is a 35-year-old man who was admitted to the ICU [intensive care unit] with respiratory failure requiring ventilator support after an overdose as a suicide attempt. An HIV viral load was mistakenly ordered and the result was consistent with active HIV infection. Mr. G was critically ill and was not improving on broad-spectrum antibiotics. No microbial information was available and, due to the HIV+ test, he was presumed to be immunocompromised. A bronchoscopy was performed and revealed an infection with *Pneumocystis carinii* pneumonia. The patient was treated appropriately, but was difficult to wean off the ventilator. The patient was extremely anxious and spent many days awake, intubated, and repeatedly failed spontaneous breathing trials. An HIV test was offered and declined by the patient. Attempts to find a surrogate decision maker were unsuccessful. Due to Mr. G.'s extreme anxiety, the team decided to wait until he was extubated and less anxious to disclose his HIV status. After the patient was extubated, the team told the patient the HIV test was inappropriately ordered and disclosed the results. The patient then told the team that his former partner had just died of an AIDS-related illness and that his grief and fear of his own HIV status both contributed to his suicide attempt.

DISCLOSE OR NOT?

The reasons for offering to disclose information to patients are summarized in table 2. Most patients want to know their diagnosis, even if it is unfavorable.[2] They need full disclosure of their diagnosis or condition to move forward with decision making and planning for the future. In addition, once a piece of information is withheld, more deception is often required to keep it from the patient. For example, if a child

TABLE 1 Considerations for Disclosing Information and Strategies for Physicians to Address Them

Considerations for Disclosure	Strategies for Physicians
Who discloses the information	Physician with most long-standing, trusting relationship with patient should disclose the information
Where to disclose	Create a private, quiet setting for disclosure Delay complete disclosure until optimal setting is obtained
When to disclose	Assess patient's ability to cope with information Address barriers to understanding and coping
What to say to the patient	Determine patient's readiness for information Fit pace of disclosure to patient Use simple, unambiguous language Provide empathy and support

would like to keep the diagnosis of cancer from an ailing parent, healthcare workers need to provide the patient another explanation of illness. In reality, to keep a diagnosis from a patient is often impossible. Many members of the healthcare team will be directly involved with the patient but will not be aware of the decision to withhold information.

These cases suggest the type of harms that might justify withholding information from patients, at least partially or temporarily. In these cases, disclosure might lead directly to serious, immediate harm to the patient. In case 2, the patient's suicide attempt suggests severe mental illness and a danger that disclosure of an incurable illness might lead the patient to harm himself or others. Furthermore, anxiety was making extubation more difficult. Under these circumstances, disclosure may be postponed until the patient is extubated and further psychiatric assessment can be obtained. In case 1, the patient's anxiety, pain, and mistrust of her surroundings was exacerbated by the commotion in the emergency department. While the patient was not known to have a serious psychiatric condition, the physicians appropriately considered how to optimize the timing and setting of disclosing her serious medical condition. In other cases, a patient may specifically state that he or she does not want to know the medical information. The physician must be confident that the patient has the capacity to make that decision and is not being influenced by family or friends.

TABLE 2 Considerations for Whether to Withhold Information

Reasons to disclose information
Most patients want to know
Patients' need for information for decision making
Deception requires more deception
Might be impossible to keep the information from the patient
Reasons for withholding information
Prevent harm
Not culturally appropriate
Patient does not want to be told

Source: B. Lo, *Resolving Ethical Dilemmas: A Guide for Clinicians,* 3rd ed. (Philadelphia: Lippincott Williams & Wilkins, 2005), 45-56.

These principles are detailed in the AMA guidelines and elsewhere,[3] but we will discuss more practical issues and offer strategies for resolving difficult scenarios. The physician must evaluate the reasons to withhold or disclose information. Once the decision has been made to tell the patient the information, a framework for approaching disclosure includes deciding who will tell the patient, when, in what setting and what will be said during the disclosure (see table 1). Using our cases, we will highlight practical strategies that clinicians can use when they are confronted with difficult scenarios involving disclosing information.

WHO SHOULD DISCLOSE?

Ideally the patient's primary careprovider or a physician with a long-standing relationship with the patient should disclose a serious diagnosis to the patient. If that is not possible, as in the case with Ms E., the team member who discusses the diagnosis should be the one who is most available to spend time with the patient, answer all of her questions, and provide support. When a patient from an ethnic minority group mistrusts the medical system, involving a healthcare worker from a similar cultural background can be helpful. If a nurse has the best relationship with the patient, he or she should be present when a physician discloses the CT results. If the patient is going to be admitted to the hospital, the in-patient team, who will develop a relationship with the patient, is better suited than the ER staff to disclose an incidentally found, serious diagnosis. In the case of Mr. G., most ICUs use a team-based approach in which different people care for patients on different days, rather than one primary individual. In this case also, the person with the most trusting relationship with the patient should disclose information to the patient.

WHEN TO DISCLOSE?

The timing of disclosure is crucial. The physician should consider the patient's readiness to absorb information, in addition to what is happening around the patient at the time of disclosure. It may be desirable to defer disclosure until reversible barriers to good communication have been overcome. In the case of Ms E., specific issues that should be addressed include pain, the central nervous system side-effects of medications, and anxi-

ety. In the case of Mr. G., his suicide attempt and his anxiety at being on a ventilator were pertinent concerns. Disclosure of his HIV status was postponed until he was extubated and psychiatric consultation was obtained.

WHERE TO DISCLOSE?

Neither the ER nor the ICU is an ideal place for a private, sensitive conversation. Yet simple measures can help create a calm, confidential environment. These include closing doors or curtains, turning off alarms, and obtaining comfortable seating that allows level eye contact with the patient. Pagers should be turned to silent or given to a colleague. Ancillary staff should be informed that there is going to be an important discussion and should be asked to avoid unnecessary interruption.

WHAT TO SAY TO THE PATIENT?

As physicians, the words we choose to use can help patients understand and cope with bad news.[4] In the case of Mr. G., the physicians could have started by evaluating Mr. G.'s own assessment of his situation: "Mr. G., what is your understanding of your condition?" This open-ended question should elicit the patient's fears regarding HIV infection. This information would help the team disclose his HIV test results. Next, the physician can ascertain the patient's readiness to hear the information with a warning that bad news is coming: "Ms E., I am afraid I have some bad news. Do you feel like talking now?" This could be followed with a step-wise approach to disclosure based on how much information Ms E. wanted to hear at that time. Telling Ms E. that something serious was seen on her CT scan, that needs further medical attention, imparts the seriousness of the condition without overwhelming her with information.

In the case of Mr. G., it was essential to admit that the test was sent in error. "A test was sent by mistake that gives us important information about your health. We apologize for sending for this test without your knowledge. Now that we have the results, we would like to discuss them with you. Would you like to do that now?" Ideally, ascertaining the patient's preferences regarding information happen before a test is ordered, but this approach can be used for incidental findings, tests sent in error, or other situations in which discussions before the test are impossible.

When partial disclosure is chosen, a plan must then be put in place for full disclosure. At that later time, it is best to use simple, unambiguous, lay terms such as, "I'm sorry that the CT scan shows some bad news. I'm afraid you might have cancer." Keeping the information simple and concise will allow the patient to absorb what she or he can. The physician should then pause, allow the patient to react, and then address the patient's immediate concerns. As in all sensitive interactions, it is important to show empathy and support, and to reassure the patient that she or he will receive the best care possible.

HOW SHOULD SPECIAL ISSUES BE ADDRESSED?

Our two cases raise unusual concerns that deserve additional comment. If a patient leaves the hospital against medical advice after hearing of a serious diagnosis, as occurred with Ms E., steps should be taken to attempt to keep her in care. The ER can make a follow-up telephone call or send a letter to the patient or to the patient's primary physician. The case of Mr. G. was complicated because the HIV antibody test was sent by mistake. The error should be disclosed as such to the patient.[5] However, there are strong reasons to obtain HIV testing for a critically ill patient who is not improving and who may have an opportunistic infection that would require a radical change in treatment.[6] When the patient is unable to make a decision, a surrogate decision maker should be sought to give surrogate consent. If no surrogate can be identified, as in the case of Mr. G., it may be medically and ethically appropriate to obtain an HIV test without consent. If this occurs, the physicians need to explain reasons for obtaining the test when the patient recovers sufficiently to understand.

CONCLUSION

The AMA guidelines provide physicians with a solid framework with which to think through difficult situations of withholding information from patients. Our two cases add to this framework by posing a series

of practical questions for clinicians who are disclosing information to patients. These questions shift the focus from *whether* to disclose information to *how to do so* in ways that minimize harms and maximize benefits to patients. By addressing these questions, physicians can continue to build on the trust and communication that is at the heart of any doctor-patient relationship.

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NOTES

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