

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-A-06

Subject: Withholding Information from Patients (Therapeutic Privilege)

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Referred to: Reference Committee on Amendments to Constitution and Bylaws
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1 INTRODUCTION

2
3 Some physicians have withheld medical information from patients when they have believed full
4 disclosure to be medically contraindicated, to avoid potential harm to the patient's physical or
5 psychological well-being. This practice, commonly referred to as "therapeutic privilege," is
6 distinct from circumstances when it is not feasible to disclose information to a patient, such as
7 emergency situations or other instances when a patient lacks the capacity of making decisions (see
8 E-8.08, "Informed Consent" and E-8.081, "Surrogate Decision Making"). It also is distinct from
9 disclosure issues that arise from medical errors, which the Council addressed in a previous report
10 (see E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm").

11
12 Intentionally withholding information may be viewed as presenting a conflict between a
13 physician's ethical imperative to protect patients and a physician's ethical obligation to be truthful
14 and to provide patients with relevant medical information. Moreover, it abrogates the process of
15 shared decision-making and conflicts with contemporary expectations that physicians will respect
16 patients' autonomy and enable them to take an active role in making treatment decisions that reflect
17 their interests and preferences. It is in this context that this report re-examines the ethical propriety
18 of withholding medical information from patients.

19 20 ETHICAL ANALYSIS

21
22 Non-disclosure of medical information was once uncontroversial when paternalism afforded
23 physicians broad discretion in making treatment decisions on behalf of their patients. Stemming
24 from the Hippocratic tradition, physicians were ethically obligated to promote their patients'
25 welfare by providing care in accordance with their own judgment regarding the most appropriate
26 course of treatment.¹ Physicians could opt not to share potentially distressing diagnostic or
27 prognostic medical information with patients if they believed that disclosure might prove
28 detrimental to patients' well-being.² Accordingly, the selective withholding of medical information

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1 could be viewed as fulfilling physicians' obligations both to act beneficently² and to promote
2 patients' overall well-being.³
3 This practice of non-disclosure was well established in the foundational works of Western medical
4 ethics, such as Percival's *Medical Ethics*, which promoted the beneficent withholding of medical
5 information to minimize patients' distress.⁴ Similarly, the 1847 AMA *Code of Medical Ethics*
6 stated that physicians had a "sacred duty...to avoid all things which have a tendency to discourage
7 the patient and depress his spirits."⁵ These guidelines helped to establish legal precedents that
8 allowed physicians to withhold potentially harmful information from their patients in the event that
9 full disclosure would impede patients' abilities to render rational decisions or harm them in other
10 ways.⁶

11
12 In recent decades, medical paternalism has given way to the contemporary concepts of patient
13 autonomy and shared decision-making.⁷ Today, physicians are called upon to promote patients'
14 well-being by openly discussing the balance between anticipated benefits of a given intervention
15 and its potential harms.⁸ In some instances, a case-specific balance of benefits and harms may
16 appear to some physicians as justification to withhold medical information, with the beneficent
17 desire to protect patients from potential harms. However, a physician's concealment of medical
18 information may not prove beneficent if it contravenes a patient's own wishes.

19
20 Many patients want detailed medical information, even if it means receiving adverse diagnostic or
21 prognostic information.^{9,10} Physicians' communication of detailed medical information has been
22 shown to ease patients' anxiety and improve health outcomes.⁵ Moreover, increased levels of
23 communication and information sharing may also contribute to higher levels of patient
24 satisfaction¹¹ and potentially decrease malpractice liability.¹² Conversely, the lack of adequate
25 information may preclude patients from receiving necessary medical attention or making optimal
26 life decisions on the basis of their individual needs and personal values.^{13,14}

27
28 Withholding pertinent medical information from patients without their knowledge or consent may
29 also have negative long-term consequences for the medical profession. The patient-physician
30 relationship is founded upon trust, because patients must rely upon their physicians to provide the
31 information needed to make a properly informed decision.¹⁵ Lack of candid disclosure can
32 compromise this relationship if patients suspect (or later discover) that information is being
33 withheld from them.¹⁶ Thus, individual physicians' purportedly benevolent acts of deception risk
34 undermining not only individuals, but also public confidence and trust in the medical profession.¹⁷

35
36 In practice, medical information should never be permanently withheld from the patient because
37 doing so represents a clear violation of patients' trust. However, physicians' obligation of
38 beneficence may allow (or compel) them to postpone the full disclosure of information to patients
39 whose capacity to make competent medical decisions may be compromised, or when disclosure is
40 otherwise medically contraindicated.¹⁸ Delayed disclosure, however, is not justified when
41 physicians merely intend to prevent a patient's refusal of medically necessary treatments,¹⁹ or to
42 instill hope for the future.²⁰

43
44 Little is known of the extent to which disclosure of alarming medical information may ultimately
45 harm patients.²¹ Physicians are encouraged to consult colleagues or hospital ethics committees

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1 when considering the need to temporarily withhold medical information from their patients. Such
2 consultations reflect respect for patients' right of self-determination and can be of real help to
3 physicians in assessing available alternatives to postponement of communicating medical
4 information.

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

9
10 **PROMOTING PATIENT-PHYSICIAN COMMUNICATION**

11
12 Physicians' concerns about disclosure of potentially harmful information should lead them to
13 encourage patients to make choices regarding the receipt of medical information before potentially
14 harmful information becomes available.²² Physicians should tailor their disclosure of medical
15 information in response to the needs, expectations and preferences of individual patients.²³

16
17 To respect patients' rights of decisional autonomy, physicians must offer all patients the
18 opportunity to receive relevant medical information.²⁴ This may be accomplished by asking
19 patients to specify the scope of information they wish to receive and their preferred methods for
20 receiving it. Physicians should then honor these preferences to the extent practicable.

21
22 Some patients may want certain medical information to be withheld.²⁵ Others may wish to involve
23 family members in the decision-making process or, alternatively, to appoint family members or
24 trusted caregivers to act as their proxy.²⁶ Physicians should respect the wishes of competent
25 patients, including accommodation of their cultural and religious beliefs.²⁷ However, physicians
26 should consider patients' decisions sensitively to ensure that their requests are not coerced and
27 genuinely represent the patients' preferences.¹³ Additionally, physicians should educate patients
28 and their proxies about the importance of disclosure and shared decision-making.¹³

29
30 When communicating medical information, physicians should assess the amount of information
31 that patients want and are capable of receiving at a given time.²⁸ Clinical judgment is required to
32 determine the appropriate means for communicating relevant information, taking patients'
33 personalities and clinical histories into account when possible.² Information should be presented in
34 a way that patients can understand and use in making medical decisions.¹³ Finally, physicians
35 should attempt to confirm that this information has been understood—for example, by asking them
36 to repeat what they have been told—and providing further clarification as necessary.^{29,30}

37
38 Physicians should communicate all requested medical information sensitively and respectfully,³¹
39 while seeking to minimize any negative effects upon the patient.³² By listening to patients'
40 concerns and responding to their individual needs, physicians can promote the patient-physician
41 relationship³³ and protect against the iatrogenic suffering of patients.³⁴ Physicians can also
42 minimize potential harms by monitoring patients' well-being and by helping them to access
43 appropriate support services, when needed.²¹

44

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1 CONCLUSION

2

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

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1 **RECOMMENDATIONS**

2
3 The Council on Ethical and Judicial Affairs recommends:

- 4
5 (1) That the following statement be adopted as new policy, to be subsequently issued as a new
6 ethical opinion:

7
8 Withholding pertinent medical information from patients under the belief that disclosure is
9 medically contraindicated, a practice known as “therapeutic privilege,” creates a conflict
10 between the physician’s obligations to promote patients’ welfare and respect for their autonomy
11 by communicating truthfully. Therapeutic privilege does not encompass withholding medical
12 information in emergency situations, or reporting medical errors (see E-8.08, “Informed
13 Consent,” and E-8.121, “Ethical Responsibility to Study and Prevent Error and Harm”).

14
15 Withholding medical information from patients without their knowledge or consent is ethically
16 unacceptable. Physicians should encourage patients to specify their preferences regarding
17 communication of their medical information, preferably before the information becomes
18 available. Moreover, physicians should honor patient requests not to be informed of certain
19 medical information or to convey the information to a designated proxy, provided these
20 requests appear to genuinely represent the patient’s own wishes.

21
22 All information need not be communicated to the patient immediately or all at once; physicians
23 should assess the amount of information a patient is capable of receiving at a given time,
24 delaying the remainder to a later, more suitable time, and should tailor disclosure to meet
25 patients’ needs and expectations in light of their preferences.

26
27 Physicians may consider delaying disclosure only if early communication is clearly
28 contraindicated. Physicians should continue to monitor the patient carefully and offer complete
29 disclosure when the patient is able to decide whether or not to receive this information. This
30 should be done according to a definite plan, so that disclosure is not permanently delayed.
31 Consultation with patients’ families, colleagues or an ethics committee may help in assessing
32 the balance of benefits and harms associated with delayed disclosure. In all circumstances,
33 physicians should communicate with patients sensitively and respectfully.

34
35 (New HOD/CEJA Policy)

- 36
37 (2) That amendments to Opinion E-8.08, “Informed Consent,” proposed below be made at the time
38 the statement above is issued as a new opinion:

39
40 E-8.08, “Informed Consent”

41
42 The patient’s right of self-decision can be effectively exercised only if the patient possesses
43 enough information to enable an ~~intelligent~~ informed choice. The patient should make his or
44 her own determination on treatment. The physician’s obligation is to present the medical facts
45 accurately to the patient or to the individual responsible for the patient’s care and to make

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1 recommendations for management in accordance with good medical practice. The physician
2 has an ethical obligation to help the patient make choices from among the therapeutic
3 alternatives consistent with good medical practice. Informed consent is a basic ~~social policy~~ in
4 both ethics and law that physicians must honor, for which exceptions are permitted: (1) where
5 ~~the~~ unless the patient is unconscious or otherwise incapable of consenting and harm from
6 failure to treat is imminent. In special circumstances, it may be appropriate to postpone
7 disclosure of information, (see Opinion E-8.122, “Withholding Information from Patients”). ~~or~~
8 ~~(2) when risk disclosure poses such an immediate and serious psychological threat of detriment~~
9 ~~to the patient as to be medically contraindicated~~ Social policy does not accept the paternalistic
10 view that the physician may remain silent because divulgence might prompt the patient to
11 forego needed therapy. Rational, informed patients should not be expected to act uniformly,
12 even under similar circumstances, in agreeing to or refusing treatment.

13
14 Physicians should sensitively and respectfully disclose all relevant medical information to
15 patients. The quantity and specificity of this information should be tailored to meet the
16 preferences and needs of individual patients. Physicians need not communicate all information
17 at one time, but should assess the amount of information that patients are capable of receiving
18 at a given time and present the remainder when appropriate. (I, II, ~~III~~, IV, V, VIII)

19
20 Issued March 1981. Updated June 2006, based on the Report “Withholding Information from
21 Patients (Therapeutic Privilege).”

22
23 (Modify HOD/CEJA Policy)

24
25 (3) That the remainder of the report be filed.

Fiscal Note: Staff cost estimated at less than \$500 to implement.

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REFERENCES

- ¹ Meisel, A. The 'exceptions' to the informed consent doctrine: Striking a balance between competing values in medical decision making *Wis. L. Rev.* 1979; 413 at 460 n. 153.
- ² Novack, D., et al. Physicians' attitudes toward using deception to resolve difficult ethical problems. *JAMA.* 1989;261(20):2980-85.
- ³ Barber, B. *Informed Consent to Medical Therapy and Research.* New Brunswick, NJ: Rutgers University Press. 1980: 37.
- ⁴ Wolpe, P. R. The Triumph of Autonomy in American Bioethics: A Sociological View. in *Bioethics and Society.* Devries, R., Subedi, J. (eds). Upper Saddle River, New Jersey: Prentice Hall. 1998;39.
- ⁵ Boyle, R. Communication, Truth-telling, and Disclosure from *Introduction to Clinical Ethics.* Fletcher, J., et al (eds). Frederick, Md.: University Publishing Group. 1997:56-57.
- ⁶ 464 F.2e 772 (D.C. Cir 1972); *Natanson v. Kline*, 350 P.2d 1903 (Kan. 1960).
- ⁷ CEJA Opinion E-8.08, "Informed Consent."
- ⁸ CEJA Opinion E-10.015, "The Patient-Physician Relationship."
- ⁹ Marzanski, M. Would you like to know what is wrong with you? On telling the truth to patients with dementia. *Journal of Medical Ethics.* 2000;26:108-13.
- ¹⁰ Silverstein, M., et al. ALS and life-sustaining therapy: patients desires for information, participation in decision-making, and life-sustaining therapy. *Mayo Clin Proc.* 1991;66:906-13.
- ¹¹ Kaplan, S., et al. Characteristics of physicians with participatory decision-making styles. *Ann Intern Med.* 1996; 124: 497-504.
- ¹² Levinson W. Physician-patient communication: A key to malpractice prevention. *JAMA*;1994;272:1619-1620.
- ¹³ Herbert, P., Hoffmaster, B., Glass, K., Singer, P. Bioethics for physicians: 7. Truth telling. *Can Med Assoc J.* 1997;156(2): 225-8.
- ¹⁴ Weeks, J., et al. Relationship between cancer patients' predictions or prognosis and their treatment preferences. *JAMA.* 1998;279(21):1709-14.
- ¹⁵ CEJA Opinion E-10.01, "Fundamental Elements of the Patient-Physician Relationship"
- ¹⁶ Conn, J., Gillman, M., Conway, S. Ethics in practice: Revealing the diagnosis of androgen insensitivity syndrome in adulthood. *BMJ.* 2005;331:628-30.
- ¹⁷ Bok, S. *Lying: Moral choice in public and private life.* New York: Vintage Books, 1979;28.
- ¹⁸ Cote, A. Telling the truth? Disclosure, therapeutic privilege and intersexuality in children. *Health Law Journal.* 2000;8:199-216.
- ¹⁹ Wynia, M. Invoking therapeutic privilege. *AMA Virtual Mentor.* Accessible at: <http://www.ama-assn.org/ama/pub/category/print/11937.html>.
- ²⁰ Annas, G. Informed consent, cancer, and truth in prognosis. *NEJM.* 1994;330:233-35.
- ²¹ Buckman, R. *How to Break Bad News: A Guide for Health Care Professionals.* Baltimore: The Johns Hopkins University Press. 1992; 53
- ²² Patterson, E. Therapeutic justification for withholding medical information: What you don't know can't hurt you, or can it? *Nebraska Law Rev.* 1985;65:721.
- ²³ Weston W. Informed and shared decision-making: The crux of patient-centred care. *CMAJ.* 2001;165(4):434-9.
- ²⁴ Freedman, B. Offering truth: one ethical approach to the uninformed cancer patient. *Arch Intern Med.* 1993;153:572-6.
- ²⁵ Pietsky, D. The breakthrough. *Ann Intern Med.* 1996;124:345-7.
- ²⁶ Surbone, A. Letter from Italy: Truth telling to the patient. *JAMA.* 1992;268:1661-2.
- ²⁷ Etchells E, Sharpe G, Burgess M, et al. Bioethics for clinicians: 2. Disclosure. *CMAJ* 1996; 155: 387-391.
- ²⁸ British Medical Association. *Human Genetics, Choice and Responsibility.* Oxford: Oxford University Press. 1998:86-8..

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²⁹ Schillinger D, Piette J, Grumbach K, Wang F, Wilson C, Daher C, Leong-Grotz K, Castro C, Bindman AB. Closing the loop: physician communication with diabetic patients who have low health literacy. *Arch Intern Med.* 2003 Jan 13;163(1):83-90.

³⁰ National Quality Forum (NQF). *Implementing a National Voluntary Consensus Standard for Informed Consent: A User's Guide for Healthcare Professionals.* Washington, DC: National Quality Forum; 2005.

³¹ Jackson, J. On the morality of deception- does method matter? A reply to David Bakhurst. *Journal of Medical Ethics.* 1993;19:183-7.

³² Weiss, G. Patients' Rights: Who should know what?. *Medical Economics.* 2002;19:97.

³³ Buckman, R. *How to Break Bad News: A Guide for Health Care Professionals.* Baltimore: The Johns Hopkins University Press. 1992; 11.

³⁴ Da Silvia, et al. Not telling the truth in the patient-physician relationship. *Bioethics.* 2003;17:417-24.

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