INFORMATION DISCLOSURE
IN CLINICAL PRACTICE:
A LEGAL, ETHICAL AND PROFESSIONAL
ANALYSIS

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degree of
PhD in Bioethics and Medical Jurisprudence

in the Faculty of Humanities
School of Law

Kate Zubairu
2013
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Abstract

Kate Zubairu
PhD Bioethics and Medical Jurisprudence, University of Manchester
31st October 2013

Information disclosure in clinical practice: a legal, ethical and professional analysis

This thesis analyses information disclosure in clinical practice from a legal, ethical and professional perspective. It examines therapeutic privilege, the duty of candour and the application of virtue ethics to truth-telling in nursing practice. I argue that each of these areas requires further clarity, articulation and application in order to assist the decision-making process of health care professionals and improve disclosure practices. In analysing these areas this thesis recognises the context of disclosure practices in relation to respect for patient autonomy and trust in the patient-health care professional relationship.

The first published paper at the core of this thesis considers the status of therapeutic privilege in English law and concludes that further clarification is needed to establish its legitimacy. I argue that the shift in English law towards a disclosure standard judged by reference to the reasonable patient requires a doctrine of therapeutic privilege. There are strong ethical arguments in favour of information disclosure, particularly founded on respect for patient autonomy. As such, further clarification is needed to identify and define the grounds on which this exception exists, when the information can lawfully be withheld and how this exception extends to the rest of the health care team, particularly nurses.

The second paper examines the ethical and practical considerations that underpin the disclosure of medical errors to patients. This provides a foundation for a discussion of how the law can best support a duty of candour. I argue for the introduction of a statutory duty of candour and analyse the current legal mechanisms and proposals for addressing this issue.

The final paper argues that virtue ethics is a useful approach from which to explore decisions relating to information disclosure. Its explicit focus upon moral character, the role of emotion, intention and the importance of practical judgement are considered from the nurse's perspective.

This thesis contributes to the dialogue on information disclosure on a number of levels. In terms of methodological approach, it recognises the importance of the synthesis of law and ethics in addressing issues in clinical practice. It uses an interdisciplinary approach, incorporating both legal and ethical perspectives, to examine the substantive questions as well as incorporating reference to empirical research to further underpin its normative claims. Moreover, this thesis considers the nursing perspective in relation to issues of information disclosure to explore the role of the nurse in decision-making regarding disclosure practices.
Declaration

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For my Mum and Dad
Acknowledgments

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I was lucky to be the first cohort of the PhD Bioethics and Medical Jurisprudence. Starting the PhD with a cohort of fellow students was really enjoyable. I would particularly like to thank Marleen Eijkholt. Marleen’s constant support, encouragement and stimulating discussion about all things Bioethics has been valued, together with becoming a treasured friend. Further thanks needs to go to my friends at my day job as a lecturer who have provided lots of laughs and support. A special thanks to Joann Kiernan who not only gave much needed encouragement, but also copious amounts of chocolate.

This work is dedicated to my Mum and Dad. I would like to express my gratitude to my Dad who has been there every step of the PhD journey, ready to talk over different aspects of the thesis and to give me much needed calm and sensible words. I cherish the memory of my wonderful Mum and the constant love and belief she had in me.

Most importantly, I could not have completed this PhD without the help, love and unwavering support of my husband, Abdul. Thank you so much for all those weekends when you have taken charge at home and given me time to work. You have been my rock throughout this process. I thank my little boy Isaac who has enjoyed making towers out of my piles of books and papers for the PhD. Finally, I would like to remember Isaac’s beautiful brother, Caleb.
The Author

Kate Zubairu's (nee Hodkinson) clinical health care background is nursing. Kate worked within the Accident and Emergency Department at the Royal Liverpool University Trust Hospital. During her time there she progressed through from the position of Staff Nurse culminating in becoming a Sister. In 2005 Kate became a lecturer in a School of Nursing at the University of Salford. In 2007 she commenced as a Senior Lecturer in the Faculty of Health and Social Care at Edge Hill University. Kate’s academic qualifications include a Diploma in Higher Education in Adult Nursing, BSc (Hons) in Health Care Practice, MSc in the Ethics of Health Care and a Postgraduate Certificate in Higher Education and Research.

Conference presentations

As a work in progress elements of this thesis have been presented at the following conferences:


Papers

The substance of the doctoral thesis is built upon a series of three papers. Two of these articles have been published and the third is in the process of submission:


Table of cases

AB and Others v Leeds Teaching Hospital NHS Trust and another [2004] 3 FCR 324
Arato v Avedon 5th Cal 4th 1172 23 Cal. Rptr 2d 131-858 P2d 598
Bolam v Friern Hospital Management Committee [1957] 1 WLR 582
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Canterbury v Spence 464 F. 2d 772 (D.C. Cir. 1972)
Chatterton v Gerson and Another [1981] 1 All ER 257
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Naylor v Preston Area Health Authority and other appeals [1987] 2 All ER 353
N M v Lanarkshire Health Board [2013] CSIH 3
Pearce and Another v United Bristol Health Care NHS Trust [1998] 47 BMLR 118
Powell and Another v Boldaz and others [1997] 39 BMLR 35.
Prendergast v Sam and Dee Ltd [1989] 1 Med LR 36
R v Mid-Glamorgan FSHA ex parte Martin 16 BMLR 81
Reibl v Hughes [1980] 2 S.C.R. 880
Rogers v Whitaker [1992] 16 BMLR 148
Rosenberg v Percival [2001] 205 CLR 434
Sidaway v Bethlem Royal Hospital Governors and Others [1985] 1 All E.R. 643
Wilsher v Essex Area Health Authority [1986] 3 All ER 801

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Protection from Harassment Act 1997
Chapter One
Posing the problem

1.1 Research questions and rationale

The intention of this thesis is to explore the legal and ethical tools relating to information disclosure which require further articulation and application in order to assist the decision-making of health care professionals.\(^1\) The three areas of study comprising the substantive body of the thesis are: therapeutic privilege,\(^2\) the duty of candour\(^3\) and the application of virtue ethics to truth-telling in nursing practice. Underpinning this investigation is the claim that each area would benefit from further legal and ethical analysis in order to provide greater clarity to those practising in the clinical health care context. The cumulative outcome of this analysis is to bring a sense of holistic clarity to issues of information disclosure and to signpost a way forward for its future ethical and legal development.

In order to contribute to the overarching purpose of this work the central areas for study can be distilled into three key research questions:

1) What is the validity of therapeutic privilege in English law?

2) How can a legal duty of candour most effectively be enshrined in English law?

3) To what extent is virtue ethics a useful ethical approach to apply to issues of truth-telling for nurses?

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\(^1\) In the overall context of this thesis the terms ‘health care professionals’, ‘clinicians’ and ‘practitioners’ essentially refer to doctors and nurses. However, a unique contribution of this thesis is to focus on the position of nurses in relation to particular areas of this study.


\(^3\) Candour in the context of disclosure after a medical error is defined as, ‘ensuring that patients harmed by a health care service are informed of the fact and that a remedy is offered whether or not a complaint has been made or question asked about it’ R. Francis, *The Mid-Staffordshire NHS Foundation Trust Public Inquiry. Final report* (2013) available at [http://www.midstaffspublicinquiry.com](http://www.midstaffspublicinquiry.com) [accessed 20th June 2013] p7.
These subjects warrant enquiry as the importance of providing patients with accurate information on which to base their decisions regarding their own health care has been established from an ethical, legal and professional perspective. As such, the foundation of the relationship between the health care professional and patient is built on the notion of trust. Ultimately, decisions regarding information disclosure affect not only the patient’s trust in those providing their health care but also contribute to a wider societal perception of health care professionals and their institutions.

1.2 The problem

In many cases, the disclosure of information to patients is relatively straightforward. However, there are instances that pose difficult ethical and professional questions and circumstances that test the boundaries of current law. Therapeutic privilege is an important legal issue because its use has been questioned as ethically problematic. Although the medico-legal literature explores information disclosure in relation to risk disclosure and consent processes, further examination is required into the nature and extent of the legal exceptions to the duty to disclose. Given that current English law recognises there may be circumstances when information may need to be withheld in order

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to avoid serious harm to the patient, further clarification is needed to identify and define the grounds on which such an exception exists, the information that could lawfully be withheld, and how this exception extends to the rest of the health care team, particularly nurses.

Despite the ethical and practical justifications for introducing a legal duty of candour there is no consensus on whether a duty of candour should be represented in contract or statute law, the scope of any duty of candour, and how it could operate in practice. For the purposes of this thesis, I focus on exploring a duty of candour in the specific context of the disclosure of medical errors. I argue that the best way to provide a legal framework for disclosing medical errors to patients is through a statutory duty of candour that would create a universally enforceable obligation. In doing so, it would help support a cultural shift in the health care context to one of openness and bring the law into line with professional guidelines.

This thesis finally interrogates how a nurse should approach truth-telling with a patient in the context of a given end-of-life scenario. I argue that, in comparative terms, virtue ethics is the most useful theoretical approach to use as it is most

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9 For example Sidaway v Bethlem Royal Hospital Governors and Others [1985] 1 All E.R. 643 per Lord Templeman para 664-666; Chester v Afshar [2004] UKHL 41 per Lord Steyn para 16.
readily and successfully applied to nursing practice. Here, I provide counter-arguments to those who question the validity of applying virtue ethics to clinical practice. The application of virtue ethics to a clinical scenario offers a wider perspective of nursing practice. This, in turn, allows consideration of the virtues required of a nurse, the consistency of these virtues, and their compatibility with the moral traditions of the nursing profession.

1.3 Methodology

The research questions within this thesis are examined using two distinctive research methodologies: engagement with empirical research and a synthesis of law and ethics. One commonality these methods have is that they attempt to provide a fusion of ideas and approaches in order to examine the legal, ethical and professional aspects of information disclosure. Empirical research is integrated throughout the areas of study within this thesis in order to provide support in the formulation of the normative claims. This is important in ensuring that ethical theory is framed against some empirically informed understanding of


the possibilities and limits of social action. Acknowledging the impact of the ethical, legal and professional discourse on information disclosure contributes towards a wider understanding and a more innovative response to the research questions. An interdisciplinary approach to answering the research questions contained in this bioethical and jurisprudential doctorate reflects a contemporary movement in Bioethics. By emphasising the applied nature of this field of enquiry it is acknowledged that practice can inform theory just as theory can inform practice. This iterative process is demonstrated throughout the thesis and can be seen in the ethical and legal analysis of therapeutic privilege and duty of candour together with the impact of philosophical and professional spheres of influence in the context of a clinically focused dilemma of information disclosure.

1.4 The nursing perspective

This thesis seeks to add to the existing knowledge in the fields of law and bioethics by applying this interdisciplinary methodology to spheres of inquiry which have hitherto received little or no analysis from this perspective. It also seeks to provide a centre stage for the interests, insights and perspectives of nursing staff when confronting these issues. This approach is taken because nurses working in clinical settings describe truth-telling as an area that involves ethical dilemmas. Despite patients often asking nurses for diagnostic and prognostic information it has been commented that research into truth-telling in

22 R. Bennett and A. Cribb, ‘The relevance of empirical research to bioethics: reviewing the debate’ Chapter 1 In: M. Hayry and T. Takala (Eds.) Scratching the surface of Bioethics (Amsterdam: Rodopi, 2003) pp 9-18 at p17.
nursing remains sparse compared to the medical studies. Whilst there is not an exclusive focus upon nursing, this standpoint does offer a more original perspective in highlighting a lack of clarity in relation to the law on therapeutic privilege along with an assessment of the merit of the application of virtue ethics to decisions of information disclosure. In order to justify this methodology, in what follows I consider the current literature relating to the morality of nursing and seek to establish relevant contextual pressures currently affecting nursing practice.

The literature relating to the moral problems experienced by nurses highlights a number of themes. These include: discussions of nursing as a moral endeavour; ethical practice and moral integrity in nursing; ethical activism and ethical assertiveness in nursing; the nature of nursing in relation to incorporating the practice of caring and compassion; and the moral experiences of nurses which include moral distress when faced with dilemmas in practice and, more generally, approaches to clinical moral reasoning. The connection between these multiple studies and this thesis is that they provide insight into how nurses might approach areas of clinical practice that raise ethical dilemmas and establish nursing as a practice which seeks to navigate ethical dimensions of care.

33 E. Pask, ‘Moral agency in nursing: seeing the value in the work and believing that I make a difference’, Nursing Ethics. 10 (2) (2003): 165-174.
Yet any discussion of the nature of nursing needs to take into account current influences on the profession. This provides context not only to the position of nurses in terms of their relationships with patients and the health care team, but also in relation to wider society. The role of the nurse both as a professional and as part of the health care team is currently under scrutiny and challenge from inside and outside the profession. There are questions being asked about: the standards of nurse education; how nursing is defined; and the role of the nurse in society. This is against a background of public inquiries into examples of sub-standard care from health care professionals in particular nursing. The quality of nursing care has been scrutinised as a result of these scandals. Alongside this, over the past decade nurses have developed and undertaken a whole range of extended roles traditionally performed by doctors, such as nurse clinicians diagnosing, treating and discharging patients and the prescribing of medicines. The evolving nature of extended responsibilities and duties has resulted in greater analysis in terms of where legal responsibilities and liability exist. The impact of the changing relationship between doctors and nurses has been examined together with the different perspectives these
professionals might bring to ethical dilemmas, their methods of ethical reasoning and argumentation and the issue of hierarchy and authority. Building upon this body of knowledge, this thesis provides legal analysis of the nurse’s position and level of influence within therapeutic privilege. Additionally, from a philosophical perspective, the nurse’s viewpoint is explored in relation to responding to a patient’s direct request for information.

These points also have significance in providing a context to discussing the disclosure of medical errors and a duty of candour. Although not directly addressed in the main body of the thesis there are potential challenges which nurses face in the context of the ethical and professional obligations to disclose medical errors to patients. Indeed, as a result of professional role issues of hierarchy and power can impact on nurses’ perception of ethical problems. It is important to recognise the value of an integrated and collaborative approach to these discussions and the potential pitfalls of a disclosure process that lacks these values. In the context of establishing a duty of candour, this is underscored by the need for the disclosure process to be viewed as a team event rather than one that exists within a doctor-patient conversation. The potential for a lack of integration in disclosure processes could lead to nurses sharing, ’inaccurate, incomplete, or ill-timed information with patients and their families or relying on ethically problematic strategies such as avoidance, indirect answers, or occasionally deception to negotiate patients’ and families’ valid questions about errors’.

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51 Ibid. p10.
1.5 Outline of thesis

This chapter articulated the underpinning normative claim of this thesis: there are specific legal and ethical approaches which ought to be the focus of further elucidation and application in order to give greater clarity for health care professionals in making decisions regarding information disclosure. These are therapeutic privilege, a legal duty of candour and the application of virtue ethics. The research methodology and its rationale provided the basis for the remainder of the chapter focusing on the integration of empirical research in supporting normative claims, the evolving interdisciplinary nature of bioethics and the significance of the nursing perspective.

Chapter Two provides a contextual background to the subject of information disclosure. Its purpose is to provide a landscape on which the main research questions are situated. This chapter focuses upon the role of autonomy and paternalism within decisions on information disclosure alongside the significance of trust within healthcare. Potential justifications for non-disclosure are considered together with the role of hope in disclosure decisions.

Chapter Three addresses the main philosophical approach used within this thesis: virtue ethics. I begin by providing clear reasons as to why virtue ethics was chosen as a favoured theoretical approach over and above competing theories. By outlining some key features of virtue ethics I show how these provide significant help in deciding how to act in relation to information disclosure. This theoretical choice is justified by providing counter-arguments to some of the criticisms of virtue ethics. Finally, I show how specific application of virtue ethics is useful in the health care context.

Chapter Four considers the legal aspects of information disclosure and seeks to provide a more wide-ranging narrative which underlays standards of information disclosure in law. It begins by dissecting the relationship between professional guidance and the law. I also examine how trust is currently reflected in the legal system - focusing particularly on the potential impact that the inclusion of fiduciary relationships in English medical law might present.
Chapter Five sees the start of the main body of the thesis comprising the first in a series of three articles. This paper addresses the first research question in considering the clarity and consistency of the law in relation to the scope of the exceptions to information disclosure.

Chapter Six addresses disclosure in circumstances of medical error. Here, the research question seeks to establish the best way to legally address a duty of candour. Ethical justifications, in the main related to autonomy, on which to base a legal duty of candour are examined. From this, the current legal position is evaluated, leading to recommendations in establishing a legal duty of candour in statute law.

The final paper which makes up Chapter Seven analyses truth telling from a philosophical perspective. Here, virtue ethics is used to dissect a dilemma in clinical practice in order to answer the research question of how a nurse should approach truth-telling in the context of an end of life scenario.

The concluding chapter of this thesis provides an opportunity, not only to pull together the main arguments of the thesis, but to make firm recommendations for future practice and research.
Chapter Two
Ethical and contextual background

This chapter will provide an overview of the ethical and professional background against which decisions regarding information disclosure are made. The aim of the following pages is to contribute to the understanding of how clinical practice and the attitudes of health care professionals and patients have developed in relation to disclosing information. This will be done by examining: the significance of respect for patient autonomy; the information preferences of patients illustrated by empirical research findings; notions of trust within contemporary health care; and by exploring the justifications offered for non-disclosure of information. In providing an answer to the overarching research question, proper regard must be given to the landscape of contemporary health care. The topics within this chapter are revisited, in part, within the substantive section of the thesis in relation to the specific papers. However, this chapter affords an opportunity to give a more detailed account of these issues and relate them more generally to the research question underpinning the thesis as a whole.

2.1 Context

To gain a more comprehensive understanding of the current issues around truth-telling and healthcare this thesis contends that it is important to recognise the context in which those issues are situated. Medical attitudes in the past have reflected a paternalist attitude towards disclosure of information. Research studies in the 1950s and 1960s revealed that doctors were reluctant to tell patients the truth about their diagnosis and prognosis. Indeed, it became clear

that the majority of physicians did not inform their patients about the diagnosis of cancer.\textsuperscript{55} The reasons given for this non-disclosure included concern for the patient’s emotional reaction to the news, that the patient’s family would request the patient not be informed, as well as the strong association between cancer and death.\textsuperscript{56} Empirical studies during the following decades reflected a greater level of disclosure of cancer diagnosis to patients.\textsuperscript{57} More recently, research has demonstrated an increasing emphasis on the importance of disclosing information to patients.\textsuperscript{58} Empirical studies have examined doctors' attitudes towards the use of deception in clinical practice\textsuperscript{59} revealing reasons for deception overwhelmingly based in altruism\textsuperscript{60} alongside a degree of uncertainty about precisely what should be disclosed and when it might be appropriate to exercise professional discretion.\textsuperscript{61} There have also been theoretical considerations of the moral acceptability of deceiving patients.\textsuperscript{62}

Overall, it is clear that the emphasis on truthful communication in contemporary health care is robust. This is reflected by ‘the current insistence amongst

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ethicists and others that good medical (and nursing) practice eschews deception and aspires to be open.\textsuperscript{63} Academic literature is now examining truth-telling from a philosophical,\textsuperscript{64} professional\textsuperscript{65} and ethical perspective.\textsuperscript{66} It is against this background that this thesis aims to test the extent to which ethical, professional and legal boundaries support disclosure of information and how far deception, or withholding information, is ethically, professionally and legally justifiable.

### 2.2 From paternalism to autonomy

The first step in any contemporary discussion on information disclosure is to acknowledge that the relationship between health care professionals and their patients has moved away from a paternalistic model of health care towards greater respect for patient autonomy.\textsuperscript{67} This is important as paternalism, which has been dominant throughout most of the history of medicine, has been ‘replaced in the last forty years with a strong tendency to allow patients to exercise their autonomy’.\textsuperscript{68} In the context of health care, paternalism has been understood as ‘benevolent decision-making in another’s best interests’.\textsuperscript{69} It is characterised as the, ‘intentional overriding of an individual’s preferences or actions and justifying this by appealing to the goal of benefiting or of preventing

\begin{itemize}
  \item \textsuperscript{64} For an example of a philosophical analysis see S. Bok, \textit{Lying} (New York: Vintage Books, 1999); J. Jackson, \textit{Truth, Trust and Medicine} (London: Routledge, 2001).
  \item \textsuperscript{69} A. Tuckett, ‘On paternalism, autonomy and best interests: telling the competent-aged care resident what they want to know’, \textit{International Journal of Nursing Practice}. 12 (2006)166-173 at 166.
\end{itemize}
or mitigating harm to the person whose preferences or actions are overridden. Yet paternalism is often framed in a pejorative context, to such an extent that it has ‘become a dirty word with the rise and success of the principle of respect for autonomy’. Nevertheless, it seems that the problem of medical paternalism is that of ‘rightly specifying and balancing physician beneficence and patient autonomy in the patient-physician relationship’. Within decisions relating to how much information to disclose to patients, this thesis explores how a balance can be met by challenging the scope and grounds on which exceptions to information disclosure currently exist. Furthermore, the influence of paternalism and how this manifests itself in withholding information in the best interests of the patient is examined within the legal context of therapeutic privilege, the disclosure of medical errors, and in terms of an end of life clinical scenario.

2.3 Autonomy

As I have emphasised, the effects of this shift away from paternalism towards a greater respect from patient autonomy is fundamental to current discussions of information disclosure practices. This move has led to greater scrutiny of respect for patient autonomy and what this means within the health care context. Whilst this section cannot hope to capture in detail the wealth of literature on patient autonomy, what it aims to do is provide a basis for further discussions within the thesis of the importance of respect for patient autonomy and its significance in decisions regarding information disclosure. Respecting the autonomy of

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73 For an example of this in relation to informed consent see U. Kihlbom, ‘Autonomy and negatively informed consent’, Journal of Medical Ethics. 34 (2008): 146-149. For an account arguing that patients do not require information in any more than broad terms in order to respect autonomy see T. Walker, ‘Respecting autonomy without disclosing information’, Bioethics. (2012 Apr 10. doi: 10.1111/j.1467-8519.2012.01971.x. [Epub ahead of print]).
patients has become a central ideal in modern-day health care.\textsuperscript{74} There are multiple definitions and perspectives given in relation to autonomy.\textsuperscript{75} For the purposes of this thesis, given the emphasis on autonomy in relation to patient decision-making and the significance of information disclosure, the definition offered by Beauchamp and Childress will be used to frame the discussion. Here, personal autonomy is said to encompass, ‘at a minimum, self-rule that is free from both controlling influences by others and from certain limitations such as inadequate understanding that prevents meaningful choice’.\textsuperscript{76} In this sense autonomy acknowledges that rather than decisions having to be fully autonomous they need to be as autonomous as practicable.\textsuperscript{77} However, if an individual does not have possession of all the information they require, then the necessary level of autonomous decision-making cannot occur.\textsuperscript{78} Yet, the extent to which a patient may choose not to be informed and have this based in respect for patient autonomy has been questioned.\textsuperscript{79}

2.4 Criticisms of respect for patient autonomy

Although this thesis recognises the importance of respecting patient autonomy and has this value as a core ethical underpinning when discussing disclosure practices it must be acknowledged that the dominance of respect for individual


\textsuperscript{77} Ibid, p208.


autonomy within healthcare has attracted criticism.\textsuperscript{80} Indeed, there are those who feel the concept of autonomy, in itself, become overburdened.\textsuperscript{81} Amongst the concerns related to respect for individual autonomy is that there may be some decisions and wishes made autonomously which do not deserve respect and that this focus on individual autonomy may encourage ethically questionable forms of individualism and self-expression.\textsuperscript{82} It has also been argued that an overwhelming emphasis on individual autonomy reflects consideration of this issue with a Western lens.\textsuperscript{83} Additionally, there exists the criticism that emphasis on individual autonomy fails to recognise the role that individuals have in a wider community and the relationships and obligations one has with others.\textsuperscript{84}

Further to this, it has also been argued that the notion of autonomy is inadequate within the health care context.\textsuperscript{85} This is based upon the assertion that autonomy can be too easily undermined by illness.\textsuperscript{86} Indeed, it is the individual’s experience of illness, disease and treatment which is said to limit the personal


\textsuperscript{85} A. Caplan, ‘Why autonomy needs help’, Journal of Medical Ethics. 15\textsuperscript{th} February 2012 10.11361/medethics2012-100492 [Epub ahead of print].

autonomy of patients. Moreover, a concern of an emphasis on patient autonomy is that it risks underestimating the level of understanding and knowledge required to make autonomous choices. This is expressed in the terms that patients cannot be expected to fully understand the level of information required to make informed clinical decisions as they lack the level of medical knowledge required. Similarly, it is argued that patients have difficulty in being able to understand or recall information that they are given about their health.

Further criticism of the emphasis placed upon respecting patient autonomy is that it eclipses other important values. In this sense, viewing autonomy as the governing principle risks obscuring the doctor-patient relationship and the moral standing of the patient within this relationship. Moreover, a dominance of patient autonomy can be seen to overshadow the ethical responsibilities of the patient.

The debate over the validity of the dominance of the value of patient autonomy in health care and the implications this has for clinical practice provides a central tension within this thesis. The situation is further confused by the different conceptualisations of autonomy and how these are delineated by health care professionals, patients, and academics within this field. Notwithstanding this wider dialogue, for the purposes of this thesis I will confine myself to focusing upon the extent to which information disclosure underpins respect for autonomy.

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2.5 Patients’ information preferences

Closely related to any discussion of patient autonomy is the need to consider the information requirements a patient may want or need. This is important as it offers support to the argument that providing patients with information, in general, reflects respect for patient autonomy. One significant area for development in terms of improving disclosure practices involves recognising the importance of gaining patient preferences in relation to information disclosure.

To assist with this, tools used to elicit patients’ preferences have been proposed and evaluated. There is strong empirical evidence to suggest that many patients want detailed diagnostic and prognostic information. In addition, far from increasing anxiety and distress, communicating information effectively can reduce patients’ anxiety levels. The corollary of this is that a lack of information has been linked with higher levels of worry in patients. This is captured by the sentiment that the ‘usual antidote to fear is not silence, but open discussion’.

What is important within this discussion is that there is an acknowledgement that ‘the amount of information provided to an individual should be tailored to their needs’. For an interesting discussion about why patients may want information for other purposes than decision-making see N. Manson, ‘Why do patients want information if not to take part in decision making?’ Journal of Medical Ethics. 36 (2010): 834-837.


specific needs and might change with time’.\textsuperscript{98} Moreover, this can be expressed in terms of establishing a dialogue between the doctor and patient which enables ‘the patient to control the pace and content of the conversation’.\textsuperscript{99} There are many strategies in relation to breaking bad news.\textsuperscript{100} One of the options is that of gradual disclosure and has been discussed in relation to giving patient diagnosis and prognostic information\textsuperscript{101} and in discussions with relatives of the critically ill.\textsuperscript{102} Importantly, the role of hope in this communication process is seen as significant in patient welfare, enabling the patient to ‘focus on the positive, to connect to others, and to continue to engage with life’.\textsuperscript{103}

\subsection*{2.6 Trust}

I have argued that respect for patient autonomy is fundamental within decisions of information disclosure. Further to this, it has been demonstrated overwhelmingly that patients want to remain informed about their health care. Implicit within the arguments in this thesis is the trust that is placed in health care professionals and health care institutions to disclose information. As such, the subject of trust warrants further examination. Although briefly mentioned in the main body of this thesis it is not addressed in detail. Within the context of this thesis, questions regarding information disclosure contain the implicit assumption that trust is an important issue within health care. In addition, it would be remiss not to acknowledge the current stresses and strains in terms of trust within health care professionals and institutions.


\textsuperscript{99} Ibid. p580.


Trust is seen as an essential component within this doctor-patient relationship and essential for effective therapeutic encounters. Indeed, it is so fundamental that the ‘patient-doctor relationship only works when each can trust the other’. Yet, doctors and nurses have been reported as using deception by factual omission, or vague and euphemistic responses and concealment. In this regard, it is evident that this ‘mutual trust cannot be built on deception or lies’. Trust has been studied empirically revealing the interdependence between trust and respect in the health care professional-patient relationship. Conversely, the ‘relationship most inimical to trust is the one whereby individuals are treated instrumentally’. Withholding relevant information without patients’ knowledge or consent, in addition to violating a number of ethical principles, may have negative long-term consequences for the medical profession particularly in terms of undermining the trust and confidence patients may place in the doctor.

Trusting in health care professionals and institutions raises the question of honesty and the idea that truth-telling is important because health care professionals have been reported as using deception by factual omission, or vague and euphemistic responses and concealment. In this regard, it is evident that this ‘mutual trust cannot be built on deception or lies’. Trust has been studied empirically revealing the interdependence between trust and respect in the health care professional-patient relationship. Conversely, the ‘relationship most inimical to trust is the one whereby individuals are treated instrumentally’. Withholding relevant information without patients’ knowledge or consent, in addition to violating a number of ethical principles, may have negative long-term consequences for the medical profession particularly in terms of undermining the trust and confidence patients may place in the doctor.

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professionals are generally respected for their honesty.\textsuperscript{113} Interestingly, this trust seems to extend to such a point that De Raeve\textsuperscript{114} argues that, in general, patients trust doctors and nurses to act in their best interests, without it being possible to clearly identify what this actually might mean in advance. Despite the commitment to honesty by health care professionals\textsuperscript{115} this can seem contradictory with the realities of clinical practice. These experiences reveal that, ‘despite societal perceptions and professional ethical codes there are situations where patients and families are not given specific information about the patient’s prognosis even when they ask for it’.\textsuperscript{116} This lack of honesty or outright deception, however well intentioned, can undermine the public’s confidence in the medical profession.\textsuperscript{117}

The issue of trust and confidence in health care professionals and institutions has been debated within the literature. This has led to a body of work that explores the meaning and features of trust in the context of relationships between nurses and patients\textsuperscript{118}; between doctors and patients\textsuperscript{119} and within health care systems.\textsuperscript{120} Yet, despite this emphasis on the importance of trust


\textsuperscript{115} For examples of this commitment see the professional codes of practice for doctors and nurses. General Medical Council (GMC), \textit{Good Medical Practice: duties of a doctor} (London: GMC, 2006); NMC, \textit{The Code: standards of conduct, performance and ethics for nurses and midwives}, (London: NMC, 2008).


several high profile inquiries have questioned the responses of doctors and nurses and health care institutions in relation to disclosing and acting upon poor standards of care.\textsuperscript{121} Despite concerns in relation to a crisis of trust provoked by such scandals some have viewed that this 'loss of trust' has become a 'cliché of our times'.\textsuperscript{122} Here, O'Neill argues that although evidence for a crisis of trust in society is lacking, there is evidence in support of a culture of suspicion.\textsuperscript{123} In real terms though, this differentiation between suspicion and a lack of trust does seem to be a difference without any real distinction. Notwithstanding this point, in the context of health care, I would argue that suspicion or distrust of doctors, nurses and health care institutions is a barrier to the forming of therapeutic relationships that are the basis to providing good quality health care.\textsuperscript{124} This claim needs to be tested against the current legal and ethical approaches to information disclosure. In the context of this thesis, this issue allows the current legal rules to be dissected to establish whether they have the requisite clarity to provide effective assurances in relation to information disclosure.

The place of trust in contemporary health care is significant in relation to the main research problem under examination in this thesis. This is because the legal devices under scrutiny within this thesis of therapeutic privilege and the duty of candour go to the heart of how the law regulates instances when information can be lawfully withheld and conversely the way in which the law compels disclosure. It has been well-established that trust is integral to the relationship between health care professionals and patients. This is important not only on an individual basis but in order to maintain trust in the health care professions as a whole. Part of this trust relationship involves reciprocity of disclosure. Both parties, the health care professional and the patient, need to


trust that there will be an open and honest exchange of information. One of the most valuable aspects of trust is it that patients’ trust is based, in part, not on knowing the individual doctor or nurse but is given to the profession as a whole based upon their status as a health care professional. This investment of trust places responsibility not only on individual practitioners, but also on those regulating health care professionally and legally to ensure oversight and assurances can be given that this trust is warranted. Although the real impact of the various health care scandals on public trust remains unclear, minimising and addressing potential areas of concern such as, when the law lacks clarity or legal oversight is not established, is fundamental in supporting a health care system that values trust.

2.7 Non-disclosure of information

I have so far sought to establish the arguments given in favour of disclosure of information to patients in terms of respecting patient autonomy and preserving trust in health care professionals and institutions. However, in order to provide a full picture of the context in which these decisions are made, I will now provide an overview of the justifications which have been given to support non-disclosure of information. This is important in relation to this thesis, as its main considerations are the circumstances when information could or should be lawfully, ethical or professionally withheld.

It has been recognised that the assertion that honesty is always the best policy is controversial. In the context of health care practice there exists the contention that an absolutist approach to truth-telling is not often helpful. Following this line of argument it may be justified for the doctor to withhold the information or even use the ‘paternalistic lie or the benevolent deception’ in circumstances when the disclosure of information could be harmful to the

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patient. Here, the obligation to disclose relevant, reasonably expected truths is not an absolute obligation but *prima facie*. Whilst practicing in a pluralist moral framework recognising a range of moral values, there may be other considerations that trump the duty to tell the truth. These may include the obligation not to cause great and avoidable harm or diminish hope. Yet this is a difficult balancing act, and it must be recognised that conflicts between examples of ‘benevolent paternalism’ on the part of the doctor and an increasing concern on the part of the patient to preserve their autonomy are not easily resolved.

Furthermore, one argument used to justify withholding of information is the claim that patients do not always want to know information about their health and care. These instances have been discussed in the literature primarily with a focus upon the right not to be informed of genetic information. Reasons given to support this decision not to know include that the burden of such knowledge may be unbearable and lead to severe psychological harm and have a negative effect on family life and social relationships. Indeed, to impose the truth on an individual who might not be prepared to deal with it is insensitive and can damage the relationship between the doctor, the patient and their family. A further reason to support a patient’s right not to know is that it supports the

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129 This is also considered by J. Wong, Y. Poon, E. Hui, ‘I can put the medicine in his soup, Doctor!’ *Journal of Medical Ethics*. 31 (2005): 262-265 at 264.
patient’s autonomy.\textsuperscript{135} However, whether choosing not to know and remain in ignorance based on autonomy has also been questioned.\textsuperscript{136}

A practical reason given to support non-disclosure relates to the question of whether there can ever be full disclosure of information in the health care context. The depth of information required for patients to possess is a matter of debate\textsuperscript{137} within the clinical context. The remit for disclosure is summed up in terms that, ‘doctors should disclose medically relevant information which patients could reasonably expect to be told (i.e. the expectation of which should be supported by good reasons, as judged from an external perspective).’\textsuperscript{138} The law provides one external perspective which may be used to judge the appropriateness of the level of disclosure. A substantial section in the main body of this thesis articulates the legal standard of information disclosure required for doctors and nurses to meet when communicating with patients. Yet, despite this clear expectation, there still exists the contention that a patient may not possess the level of knowledge required to understand the information, or that putting across the technicalities of medicine may be too difficult.\textsuperscript{139} Whilst it may be the case that there is a lack of training and time to conduct such conversations\textsuperscript{140}, this line of argument is not acceptable as it is inconsistent with ethical, legal and professional obligations in relation to information disclosure. Moreover, the


\textsuperscript{137} The issue of the depth of information required in relation to risk disclosure was discussed in G. Palmboom, D. Willems, N. Janssen, J. de Haes, ‘Doctors’ views on disclosing or withholding information on low risks of complication’, \textit{Journal of Medical Ethics}. \textbf{33} (2007): 67-70 at 70. They propose a culture of balanced risk disclosure where patients are given access to relevant information without forcing doctors to painstakingly discuss each and every risk, however minute.


‘arrogance (or laziness) that lies behind this attitude undermines professional
devour’.\textsuperscript{141}

Another possible reason for non-disclosure of information exists in regard to the
uncertainty surrounding a diagnosis or prognosis.\textsuperscript{142} This justification suggests
that there is no certainty in health care, therefore no ‘absolute truth’ to reveal.
This is a specific view of truth that defines it as an absolute or certain knowledge
or meaning.\textsuperscript{143} Notwithstanding that there is uncertainty in health care, this does
not amount to justification for non-disclosure as the degree of uncertainty could
be shared with the patient without affecting confidence in the clinician’s skill and
judgement.\textsuperscript{144}

It is interesting that the avoidance of harm is given as a justification for both
providing information to patients and also for withholding information.\textsuperscript{145} This
harm can include not only medical harm but a range of other harms, from
psychological distress to a breach of trust by the medical profession’.\textsuperscript{146}
Examples might include psychological and emotional harm affecting the patient’s
physical condition and ability to make decisions. Any calculation of these harms
is a difficult exercise that introduces value judgments by those making such
decisions and is susceptible to the cultural norms and practices of their working
environment. This factor provides a difficulty in using harm to support
conclusively either side of the argument. There is also the difficulty about

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\textsuperscript{142} For further discussion of this see M. Parascandola, J. Hawkins and M. Danis, ‘Patient autonomy and the challenge of clinical uncertainty’, \textit{Kennedy Institute of Ethics Journal}. \textbf{12} (3) (2002): 245-264.  
\end{flushright}
predicting what information a patient will find upsetting, or foreseeing how upsetting certain information will be.\textsuperscript{147}

2.8 Truth-telling and hope

In the previous section I gave several reasons that have been used to justify non-disclosure of information. Yet, perhaps one of the most regularly cited lines of argument that clinicians give for withholding the truth (or aspects of the truth) is that patients may be overwhelmed, may lose hope or become depressed.\textsuperscript{148}

This is important because hope is seen to be integral to a person’s quality of life and well-being.\textsuperscript{149} The significance of concerns about a loss of hope resulting from disclosure of information in relation to diagnosis or prognosis for example warrants recognition. The following section briefly acknowledges some of these fears from the perspective of the patient and the health care professional. This discussion provides insight into the potential dilemmas of information disclosure for doctors and nurses and aims to provide a context to the question of truth-telling at the end of life, which is considered later in the main body of the thesis.

The therapeutic effects of hope have been well documented throughout history\textsuperscript{150} with the importance of sustaining hope described as an intuitive part of human nature and of nursing practice.\textsuperscript{151} This is because hope in the communication process enables patients to ‘focus upon the positive, to connect with others, and to continue to engage with life’.\textsuperscript{152} However, in relation to disclosing information to patients a potential hazard that doctors and nurses can run into when trying to maintain a patient’s hope is to encourage ‘false hope’. False hope has been described as occurring when there is a strong dissociation

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between hope and expectation.\textsuperscript{153} This has clear implications for the need to manage patient’s expectations and that any misguided evasion or dishonesty may add considerably to a patient’s distress.\textsuperscript{154} The encouragement of false hope fails to respect the patient’s autonomy and in effect can be judged to be deceiving the patient.\textsuperscript{155} The dilemma facing doctors and nurses to balancing the need to give patients honest information yet knowing that this information could impact on the patient’s welfare is a real one and can be very challenging and difficult to achieve.\textsuperscript{156} Despite this acknowledgement, what can be seen in the different components of this thesis is a consistent argument that in order to meet legal, professional and professional standards of practice doctors and nurses need to have the professional skills and expertise in order to navigate these potentially difficult conversations.

2.9 Conclusion

Establishing a context to the normative claims within this thesis is important as it provides a contemporary understanding of current health care practice. The advance of respect for patient autonomy is a significant ethical justification for the provision of information to patients and one which overcomes the reasons given for non-disclosure. The importance of trust within health care is fundamental, both implicitly and explicitly, throughout the thesis and has particular significance in providing a rationale for focusing on the legal and ethical perspectives of information disclosure. These contextual issues regarding information disclosure require a philosophical underpinning. In order to provide this the following chapter will consider this question from the perspective of virtue ethics and establish the usefulness of this approach in the context of information disclosure decisions.

Chapter Three
Philosophical approach

The philosophical approach in this thesis is one of virtue ethics. In this section I will argue that virtue ethics is the most useful philosophical approach to explore issues of truth-telling from a nursing perspective. In doing so I will explain why this particular ethical approach was taken and clarify its value in examining practical issues of truth-telling in a nursing context. In order to justify this particular approach further I will evaluate and answer the arguments of those who are critical of a virtue ethics approach and show the efficiency of virtue ethics as an applied tool to dissect dilemmas in health care, and particularly nursing practice.

3.1 Virtue ethics

Virtue ethics has a rich historical perspective and has undergone various periods of decline and renaissance. This revival has resulted in an expansion and development of virtue ethics with a wide range of theoretical emphasis. Despite these different approaches there are some commonalities. Two features in particular have been highlighted: firstly, a focus on the character of the individual and with those virtues and motives that

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157 For example see the work of ancient Greek philosophers Plato and Aristotle and in the work of the thirteenth century theologian Saint Thomas Aquinas.

158 This can be seen in the replacement of discourse on virtue in the seventeenth and eighteenth centuries by a range of alternative concepts, including rights, duty, moral sentiment and utility.

159 This revival is often credited from the critique of deontological and consequentialist traditions found in G.M.Anscombe, 'Modern moral philosophy' In: R. Crisp and M. Slote (Eds.) Virtue Ethics (Oxford: Oxford University Press, 1997) pp26-44.


162 Several definitions have been offered of a virtue. Pellegrino and Thomasma define a moral virtue as, ‘a habitual disposition to act in a certain way, a way that facilitate and enriches the telos or purpose of whatever human acts we perform’ in E. Pellegrino and D. Thomasma, The Virtues in Medical Practice (Oxford: Oxford University Press, 1993) p79. Similarly, Armstrong views a virtue as, ‘a character trait, habitually performed which disposes one to act, think and
qualify him or her as being virtuous, and secondly, the use of terms describing an individual’s moral character or excellent qualities.\textsuperscript{163} What makes virtue ethics different from other theoretical approaches is it values of greatest moral import judgements about an individual’s character, disposition and motives rather than judgements about the rightness or wrongness of external acts or the consequences of acts.\textsuperscript{164} In order to answer one of the key research questions within this thesis, the following pages will consider the elements which set virtue ethics apart as an ethical approach when exploring issues around the ethics of truth-telling in nursing. Here, I focus particularly upon the significance of recognising emotion and motivation within ethical decision-making. In order to situate virtue ethics within the ethical landscape I explain the limitations of rival ethical theories in addressing issues of information disclosure whilst emphasising the merits of a virtue ethics approach.

3.2 The importance of recognising emotion in ethical decision-making

A criticism of principle-based ethical theories is that they are overly rationalistic, being too focused on cognition and rationality, with limited regard for the role of emotions in the moral life.\textsuperscript{165} For example, emotions have been viewed as having no part in rationality as they stem from the non-rational, animal side of our nature.\textsuperscript{166} By comparison, virtue ethics, seeks to accommodate the appropriate expression of emotion\textsuperscript{167}, an approach that has been understated, if not totally missing, in competing deontological and utilitarian theories.\textsuperscript{168}

\textsuperscript{165} S. Banks and A. Gallagher, Ethics in Professional Life (London: Palgrave Macmillian, 2009) p65
\textsuperscript{167} For further discussion on the value of the emphasis on emotion within virtue ethics see M. Stocker, ‘How emotions reveal value and help cure the schizophrenia of modern ethical theories’, Chapter 11 In: R. Crisp (eds) How should one live? Essays on the virtues (Oxford: Oxford University Press: 1996).
Recognising the role emotions\textsuperscript{169} play is important when making decisions as emotions form part of the lens through which we understand and respond to the world.\textsuperscript{170} In the context of health care, clinical practice has been recognised as an emotional place.\textsuperscript{171} For the purposes of this thesis, the emphasis on emotions within virtue ethics is important as they play a crucial part in contributing to ethically sensitive clinical practice that responds appropriately to patient need.\textsuperscript{172} In this sense, recognition of an emotional response is important in being able to more accurately understand the feelings which the patient is experiencing. By having this level of insight and sensitivity, the patient’s communication and health care needs can be more easily determined and responded to. As I have already identified, nursing practice has a moral dimension\textsuperscript{173} and as an understanding of emotions is seen as a crucial part of moral perception,\textsuperscript{174} this suggests that good nursing requires that the moral significance of emotions be acknowledged.\textsuperscript{175} Indeed, by recognising the role of emotions and feelings, a richer narrative account of patients lived experiences can be realised which matches the ideals of holistic and patient-centred care\textsuperscript{176} as well as prompting a more reflective approach to clinical practice.\textsuperscript{177}

\textsuperscript{169} For a fuller account of emotion in moral life see J. Oakley, Morality and the Emotions (London: Routledge, 1992).
In recognising the importance of emotion, virtue ethics must respond to the criticism that emotions detrimentally affect one's ability to reason effectively. Yet, within virtue ethics, emotions aren't valued at the expense of moral reasoning, indeed emotional responses have a rational content allowing emotions to participate in reason. Therefore one of the advantages virtue ethics holds is the ability to embrace reason whilst still recognising the role of emotions. As such, emotions are seen to be a necessary and positive ingredient in decision-making and ethical deliberation should include explicit consideration of the emotions of those deliberating. Nonetheless, the mere presence of emotions is not enough to make a decision ethical, but they do have a place alongside and integrated into ethical reasoning.

I have argued that virtue ethics provides a useful theoretical approach to explore truth-telling in a nursing context. One of the reasons for this is because virtue ethics, unlike many other ethical approaches, encourages the inclusion of emotion in decision-making. This, alongside the centrality of the role of moral character and practical judgement, helps provide a more wide-ranging analysis of decisions relating to information disclosure. This enables the subject to be reviewed, not only in terms of how the nurse should act, but also how the nurse should be. Of course, there are many other competing ethical approaches that could be applied to decisions regarding information disclosure.

Therefore, if we are to demonstrate further the value of the choice of virtue ethics I will now examine, arguably, two of the dominant ethical theories - deontology and...

178 This criticism can be seen in the history of philosophy. For example, Kant describes emotions as blind forces that overwhelm human beings in I. Kant, *Grounding of Metaphysics of Morals* (J. W. Ellington, trans) (Indianapolis: Hackett, 1993)


181 L. Gillam, C. Delany, M. Guillemin, S. Warminster, 'The role of emotions in health professional ethics teaching', *Journal of Medical Ethics.* (2012) Published online 10.1136/medethics-2012-101278.


183 L. Gillam, C. Delany, M. Guillemin, S. Warminster, 'The role of emotions in health professional ethics teaching', *Journal of Medical Ethics* (2012) Published online 10.1136/medethics-2012-101278.
consequentialism - to explore their approaches to issues of information disclosure.

### 3.3 Deontology

This thesis maintains that the application of virtue ethics is the most helpful theoretical approach when considering questions of truth-telling at the end of life. However, of course, there are other ethical approaches which could have been chosen, for example deontology. In general terms, deontological theory holds that certain kinds of actions are good, not because of the consequences they produce, but because they are right and good in themselves.\(^{184}\) Put crudely, a deontologist would say that one must always act according to moral obligations or duties.\(^{185}\) Yet, the nature of these duties is open to argument, since there is no principle on which all deontologists agree.\(^{186}\) Indeed, there exist many interpretations of deontology.\(^{187}\) These interpretations of deontology range from an absolutist approach that a person should perform their duties without exception, whatever the consequences, to those who accept that although it is sensible to consider consequences, some duties are nevertheless of supreme and abiding importance.\(^{188}\) Or alternatively, that consequences may have some bearing in justifying whether an absolute rule could be breached.\(^{189}\) Taking into account this breadth of theory, in this section and what follows on consequentialism, I will limit the application of these ethical theories to the context of information disclosure and, in doing so, highlight why virtue ethics is a more appealing theory for the purposes of this thesis.

A typical deontological approach to truth-telling might be that truth-telling is necessary for its own sake because it is assumed that lying and deception are


wrong and that clinicians, like other people, have a moral duty to tell the truth. This absolutist approach opposes deceiving patients and relatives by concealing the truth. The basis of this argument is that forms of deception fail to respect individuals as self-determining, self-governing beings. Applying this philosophy to the practice of truth-telling would dictate that a doctor or nurse would not be fulfilling their duty if they attempted to lie or deceive a patient. Here, the deontologist might argue that certain obligations and actions are right and good in themselves, regardless of consequences, or that although it is sensible to consider consequences some duties are of supreme and binding importance. However, this is an extreme application of deontology and many deontologists would recognise that there are sometimes competing moral imperatives, such as the duty to do good or the duty to avoid harm, which require decisions to be made over which should take precedence - truth-telling or withholding the truth. This acknowledges that, at times, this rule of truthfulness introduces circumstances when honesty conflicts with other similarly important concepts or binding duties. Indeed, other interpretations of deontological rules might prioritise the duty to act in the best interests of patients over the duty to tell the truth. Here, the deontologist might recognise the danger that adhering to moral absolutes (such as truth-telling) in all cases and circumstances may do more harm than good. In this sense being totally truthful, meaning to conceal nothing and disclosing everything, seems an absurd thing to advocate, particularly in the context of the uncertainties of clinical practice. In these cases, ‘Benevolent deception' has been used to justify

196 Duties have also been discussed in terms of being prima facie rather than absolute. See the work of W.D. Ross, The Right and the Good (Oxford: Oxford University Press, 2002).
withholding the truth in circumstances when telling the truth may produce great harm or when telling the patient the truth is clearly not in the patient’s best interests.\textsuperscript{200} This is done to avoid the harsh results that a rigorous application of a duty-based theory may produce.\textsuperscript{201}

Deontology, as with other ethical theories, is an approach which is used by individuals whose application demonstrates a range of interpretation and focus. Furthermore, a balanced and judicious use of ethical theory would seek to take account of the competing obligations involved and thus avoid a simplistic adherence to rigid obligations in all circumstances. Overall, virtue ethics was favoured as the ethical approach within this thesis due to its explicit focus upon the moral character of the individual involved, their emotions, motivation and moral reasoning together with an appreciation of the individual circumstances at hand. This is important as it involves the ability to be flexible and to be able to make judgements about complicated ethical problems under pressure, a process that sometimes involves arriving at sensible compromises.\textsuperscript{202}

3.4 Consequentialism

I will now consider the consequentialist critique that can be applied to truth-telling. In doing so, I will first explain some of the key features of a consequentialist approach to ethical reasoning. Notwithstanding the many different versions of consequentialism\textsuperscript{202}, in brief, a consequentialist decides how to act by assessing the likely outcomes of the proposed action and judges the morality of what was done or not done by reference to the results of the action.\textsuperscript{204} As such, a typical consequentialist would decide how to act by assessing the likely outcome of the proposed action, and judge the morality of

\textsuperscript{202} D. Seedhouse, ‘Theories of Ethics’ Chapter 6 In: \textit{The Heart of Health Care} (Chichester: Wiley, 2009) p89.
the action or inaction according to those consequences. Therefore, if faced with two alternative courses of action, the one with the best consequences should be chosen. The right act in any given situation being the one that will produce the best overall outcome. This begs the question of what counts as the best consequences. Utilitarianism, probably the most well-known consequentialist theory, proposes that in assessing consequences the only thing that matters is the amount of happiness or unhappiness that is created. Here, right actions are those that produce the greatest possible balance of happiness over unhappiness, with each person’s happiness counted as equally important. One of the appeals of consequentialism is that it appears to be a ‘common sense’ approach, in that many decisions are made in everyday life by considering consequences. Despite these appeals adhering to a consequentialist approach in moral decision-making typically has a number of drawbacks. In the following section I will consider just two of these: the narrowness of considering consequences as the only ethically relevant factor and the difficulties of predicting consequences.

Applying this ethical approach to information disclosure, a consequentialist would discuss the value of truth-telling in relation to the consequences of either telling the truth or withholding it. However, whilst consequences are important, if a radical consequentialist philosophy was applied to truth-telling this would be the only thing that would matter. In taking this approach there are several important elements that remain unexamined and which are ethically relevant. For example, further elucidation of the moral character, the motives and emotions of the individual making the decision. These factors are important as they play a part in influencing the decision which is arrived at, together with providing understanding of how this decision is reached. However, it must be

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recognised that individuals use ethical approaches such as consequentialism as tools, which reveals a range of application of ethical theory. Therefore, a more moderate consequentialist approach is able to take into account features such as the emotions which are produced by ethical decisions alongside the nuances of the particular circumstances involved. This reveals a useful account, however, virtue ethics was favoured as it provides an ethical approach that holds of central importance how nurses and doctors might think, feel and act in clinical dilemmas. Whilst consequentialism accommodates these issues, by reference to the consequences of actions, a virtue ethics approach gives primacy at the outset to moral character. In doing so virtue ethics holds that reference to character is essential in a correct account of right or wrong action.\(^{212}\) This approach was favoured in order to provide a richer account in answering the central questions in this thesis and in doing so places these issues at the heart of the analysis.

A further obstacle for consequentialists is the difficulty of predicting the outcomes of actions.\(^{213}\) Applying this to information disclosure, in attempting to consider the relative harms and benefits of non-disclosure, there is a lack of predictability of the consequences of non-disclosure in the long term.\(^{214}\) There exists the problem of multiple, and possibly unforeseen and adverse consequences.\(^{215}\) For example, if a decision is made to withhold information based on an evaluation that this would produce the best consequences for the patient, and the patient then discovers this fact, this may have unintended repercussions. One possible consequence of withholding information could be that the patient becomes concerned that they will be excluded from full involvement in decision-making.\(^{216}\) Furthermore, withholding the truth, in an attempt to foster hope, may lead to worse consequences than informing the

patient as it risks losing the patient’s trust and confidence. Although the problem of dealing with unknown consequences is often levied at a typical consequentialist approach, it remains an issue that a virtue ethics approach needs to recognise. However, as virtue ethics does not have consequences as its central and primary concern it means that the value of actions are measured by reference to other features, not solely related to consequences, such as the moral character of the individual involved.

Notwithstanding the merits of using a virtue ethics approach, there remains criticisms of this methodology, to which I will now turn.

3.5 Criticisms of virtue ethics

The following pages will examine the principle criticisms which have been levied at virtue ethics. In doing so I will provide a defence of virtue ethics in order to justify its selection as the particular ethical approach for this thesis. Indeed, virtue ethics has faced much critique, to the point where it has been argued that ‘defending virtue theory against all possible, or even likely criticisms of it would be a lifelong task’. With this in mind, I will focus upon two commonly cited and closely related criticisms: that virtue ethics lacks action guidance and that this results from its central premise being circular in nature.

3.6 Lack of action guidance and circularity

One central criticism of virtue ethics is its perceived lack of action guidance. The argument is that in complex situations where there may be competing virtues, there is no clear set of rules or guidance for actions as its central premise is circular in nature and a truism. This can be summed up by the difficulty of arguing that the virtuous agent does what is right, and is able to do

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what is right because she is a virtuous agent. The difficulty being that, although virtue ethics advocates being virtuous, this is of no help unless the person concerned knows what the virtues are and which ones to apply in the given situation. To explain this further, if they are less than fully virtuous, they will have no idea what a virtuous agent would do, and hence cannot apply the prescription virtue ethics has given.

The response to this central critique of a lack of action guidance acknowledges that if the person knows they are far from perfect and are unclear what the virtuous agent would do, then the obvious course of action would be to go and ask someone who is a virtuous agent, if that is possible. This provides moral guidance from people who we think are morally better than ourselves. Put more simply, the notion of appealing to ‘what a certain person would do’ is a quite commonly and successfully applied justification. For example, novice doctors and lawyers sometimes justify having acted in a certain way because they believe that this is how their professional mentor would have acted. Similarly, courts often rely on claims about what a reasonable person would have foreseen in those circumstances. However, it can be argued that it may be considerably more difficult to determine which of the virtuous character traits a virtuous person would act upon - as opposed to merely establishing reasonableness. More significantly, a justification of the virtue ethics approach lies in the argument that it does give detail about what virtuous agents have done, and would do, in certain situations. For example, it may be argued that each virtue generates a prescription - do what is honest, charitable, or generous – and each vice generates a prohibition - do not do what is dishonest, uncharitable, or mean. Furthermore, this criticism of a lack of action guidance is based on the unrealistic supposition that an individual might be totally clueless about the virtues involved. In this sense, if an individual has some idea of virtue, then they

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221 Ibid. p37.
223 Ibid.
could ask themselves, in any situation, what would be, for example, the compassionate or the generous thing to do.

Despite this guidance, there remains the risk that individuals might be led by virtuous character traits to act wrongly. For example, a benevolent doctor may be moved to withhold a diagnosis of terminal cancer from a patient. To answer this criticism it is important to remember that virtue ethics involves not only having good motives or dispositions, but also having a practical component which means establishing that one’s actions succeed in bringing about what the virtue dictates.\(^{227}\) Using the same example, we might then question whether it is an act of benevolence in leaving a patient in ignorance of their terminal cancer diagnosis or whether the doctor lacks other relevant virtues such as honesty. This underlines the significance of moral wisdom as part of virtue ethics in using moral reasoning to determine how to act and feel in ways appropriate to a given situation.\(^{228}\)

Therefore, part of the task in relation to virtue ethics is to consider how it may be applied to real life and, for the purposes of this thesis, health care practice. The following pages contribute to this task by highlighting examples of this application\(^ {229}\) and in doing so will test the cogency of this approach.

### 3.7 Application of virtue ethics in healthcare

In order to establish the value of virtue ethics as an ethical approach to decision-making in the health care context, I will now illustrate how virtue ethics has been used to dissect moral problems in clinical practice. By doing this I will focus on how virtue ethics has been addressed within the literature on professional


roles, specifically the philosophy of nursing and medicine. Here, I identify the body of work that exists in applying virtue ethics theory to nursing and medicine and argue that this represents a starting point on which to build a discourse on virtue ethics relevant to real world clinical practice.

Yet it must be acknowledged that there can be disagreements about how this application is achieved. Despite this, providing examples of how this theoretical approach might be applied both in clinical practice and to well-known stories, presents the opportunity to open the dialogue with clinicians about being a virtuous practitioner. To explain this further, it provides an opportunity to make connections between theoretical ethical approaches and real world clinical practice. The value of this lies in the notion that this endeavour makes virtue ethics more accessible to practitioners in a more meaningful way rather than viewing the goal of being virtuous as 'an idealistic, pseudo-goal for those aiming at sainthood'. This, in turn, provides an opportunity to identify the relevant virtues for practitioners to possess and any potential conflicts that might exist. An example of a rich vein of application of features of virtue ethics is seen in the recognition of the role of moral education in virtue ethics and how this can be applied to nursing, particularly in relation to the importance of ‘practical wisdom’ in the professional context. The discourse in virtue ethics about the

230 Virtue ethics has also been discussed from the context of its application to professional roles. For example see J. Oakley and D. Cocking, *Virtue Ethics and Professional Roles* (Cambridge: Cambridge University Press, 2001); R. Walker and P. Ivanhoe (eds), *Working Virtue* (Oxford: Oxford University Press, 2007); S. Banks and A. Gallagher, *Ethics in Professional Life* (Basingstoke: Palgrave Macmillan, 2009)


importance of moral education offers an interesting and valuable dimension in its application to nursing. This is because it introduces important questions to nurse education such as: the moral character of the practitioner and the virtues they should possess, and how good character can be assessed, as well as the fundamental question of whether virtue can be taught.

3.8 Criticisms of the application of virtue ethics to examples in healthcare

I have argued that the application of virtue ethics to clinical examples from healthcare practice is a valuable contribution to applied ethics. However, this approach has not been without its critics. This sceptical and unfavourable critique can be summed up by the position taken by Holland. Advocating the application of action-related or rule-related ethical systems to the nursing profession, he asserts the need for distinction between saying that nurses ought to possess certain virtues and applying a teleological virtue ethics framework into nursing. Implicitly, this criticism is connected to the argument that virtue ethics does not provide action guidance. To respond to the implicit criticism that teleology is not relevant in professional ethics, I concede that a pluralist society may lack a shared notion of what is good for humans and society. For the purposes of this thesis, a more reasonable approach is to confine this application of virtue ethics


242 In brief, Holland derives this conception of virtue ethics being teleological in nature from the work of Aristotle in connecting virtue and the purpose of living the good life for human beings as an end to strive towards. In doing so he asserts that whilst this connection might be present in one’s personal life it does not arise in a professional context such as nursing. For a more detailed account of this point S. Holland, ‘Scepticism about the virtue ethics approach to nursing ethics’, *Nursing Philosophy*. 11 (2010): 151-158.
to professional ethics. Here, there may be more agreement as to what is needed in order to achieve the ends of a particular profession. For example, the ends of medicine have been described as to act in the patient’s good. As such, the good doctor (or nurse) should exhibit character traits that most effectively achieve, and indeed are indispensable for, enabling the work of medicine to be done well.

Further objection can be found in reference to the mechanics application of virtue ethics to clinical practice scenarios. In a strong criticism of the way in which virtue ethics theory has been applied in nursing ethics Holland identifies that a typical structure of identifying a moral sphere of nursing activity, defining the virtues relevant to that sphere, applying them and discussing their implications has been pursued. This structure, Holland argues, is ‘massively reductionist, a distillation of virtue ethics to the bald normative requirement to “act according to the virtues” or “do what the virtuous agent would do”’. To answer the explicit criticism, I would argue that this structure is appropriate to use when trying to apply a theory to a practical problem. One of the purposes of using clinical scenarios to test out theories is to see how complex theoretical notions might be applied in a practical context. In addition to this, an important function in applying theory to clinical practice is to make this relevant to a wider audience, to include practitioners and those who might not be philosophers. Whilst the method of applying theory to clinical practice by breaking down parts of the theory and trying to convey its key messages might be seen as reductionist it seems an appropriate starting point for debate and for further complex and intricate discussions to follow which can expand on elements of the theoretical application.

246 Ibid. p154. In making this point he identifies the third paper in this thesis as a ‘paradigmatic’ example.
3.9 Conclusion

Virtue ethics is the most valuable ethical approach when considering decisions regarding information disclosure in the clinical context. Virtue ethics was favoured above other ethical theories as it explicitly recognises the role of moral character and gives primacy to the value of moral reasoning, emotions and moral education when deciding on the right course of action. Having these issues front and centre is important because they provide insight into how decisions are made and the balance between the different virtues which might be involved. In addition it also gives emphasis to the moral judgement needed as to how these virtues are taken into account to provide action guidance. Moreover, by clearly emphasising the part that emotion plays in decisions this provides a more comprehensive understanding of the decision made. Furthermore, in a disciple such as health care, understanding the importance and role of moral education is important. This is because it affects how health care professionals are inducted, taught and developed within the profession, together with how this impacts on their clinical practice. Although other ethical theories provide interesting accounts in their application to information disclosure, it is the rich narrative to the decision-making process given by virtue ethics which is valuable when applied to clinical practice.

Whilst an appropriate philosophical approach is fundamental to this thesis, there are other disciplines which require appropriate exposition in a full analysis of information disclosure in health care practice. Thus, in the following chapter I will explore the legal approach within this thesis. This will provide an important background for the more detailed account of the legal aspects of information disclosure that will be addressed in Chapters Five and Six.
Chapter Four
Legal Approach

The purpose of this thesis is to explore the legal and ethical tools which require further articulation and application in order to assist clinicians in making decisions surrounding information disclosure. Thus far, I have focused upon highlighting some of the key issues which situate information disclosure in contemporary health care practice, together with championing virtue ethics as the most effective philosophical approach in illuminating this subject. To contribute to the legal perspectives of this endeavour in the substantive section of this thesis I investigate two particular legal issues: that of therapeutic privilege and the legal duty of candour. Specifically two central questions are asked: What is the validity of therapeutic privilege in English law? How can a legal duty of candour most effectively be enshrined in law? Answers to both these questions can be found in the following chapters of this thesis. Yet, these specific legal issues relating to disclosure practices exist in a fairly limited and contested legal terrain. Therefore, in order to provide a broader basis for discussion, this legal chapter will provide a more wide-ranging legal discussion. An understanding of the effectiveness of legal obligations of disclosure and candour are enriched by accommodating important, yet hitherto largely absent dimensions such as empirical research, professional guidelines and legally useful concepts such as fiduciary relationships.

In the following sections I will focus upon two particular areas. Firstly, I will provide an analysis of the role of professional guidance within information disclosure, particularly scrutinising how these standards interact with the law against the wider interplay existing between medical law and ethics. Secondly, this chapter will refer to the previous exploration of trust within the health care context, firmly establishing its place within the general health care discourse. I then argue that this depth of inquiry is required within the legal system and propose a vehicle for achieving this by reflecting trust in the legal context of fiduciary relationships.
4.1 Professional guidance and the law

In order to explore the role of professional guidance within information disclosure practices I would first like to establish the legal significance of providing patients with information. This pertains to the central idea that the provision of information is key in order to gain consent and demonstrate its reflection of an autonomous choice.\(^{247}\) Yet, there can exist a degree of uncertainty about the level of information disclosure required.\(^{248}\) Given the importance of gaining consent it is unsurprising that the provision of sufficient, accurate information as an essential part of seeking consent is underscored by its fundamental place within professional guidelines.\(^{249}\) As such the guidelines contain a common approach to information disclosure which can be summed up by the obligation to share with patients, in a way they can understand, information they want or need to know about their health.\(^{250}\) These requirements for disclosure exist within more general obligations of openness, trust and good communication.\(^{251}\) As the professional guidance sets out for clinicians the standards of information disclosure required I will now explore the position of such guidance in law.

In English law the standard of care within medical negligence cases has traditionally been judged in relation to what a responsible body of medical opinion determines to be acceptable\(^{252}\) providing it is defensible and able to withstand logical analysis.\(^{253}\) The opportunities for embracing clinical guidance as an objective measure of determining the legal standard of care has been


\(^{252}\) *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

\(^{253}\) *Bolitho v City Hackney Health Authority* [1997] 39 BLMR per Lord Browne-Wilkinson at 243.
advocated as the use of guidelines present an opportunity to establish what might constitute a reasonable body of opinion in litigation. Yet, the extent to which clinical guidelines enjoy the force of law remains unclear. A departure from practice laid down in a guideline, as long as it remains capable of withstanding logical analysis, is reasonable and responsible, is not prima facie evidence of substandard care. Nevertheless, guidelines provide the courts with a benchmark by which to judge clinical conduct as they represent the view of respected and authoritative bodies of medical opinion. That being said, clinical guidelines are a single piece of evidence to be taken alongside expert witness testimony to help the court determine the appropriate standard of care.

This analysis shows that, at the very least, the use of clinical guidance in medical negligence litigation has been established and cannot be presumed. In itself, this raises some interesting issues in relation to the wider research question of this thesis which examines the legal and ethical tools available for making disclosure decisions. In the following pages I will examine how clinical guidance can be viewed and understood by health care professionals together with the consistency which exists between the standards of disclosure required by professional guidance and that demanded by the law.

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In the context of information disclosure there exist several guidelines which articulate recommended standards of practice for clinicians. In relation to information disclosure and consent the interplay between professional guidance and the law has been recognised. Significantly though, given the importance of standards set by the professional regulatory bodies in relation to information disclosure, it has been suggested that whilst medical practitioners may be aware of guidance regarding consent processes there is a lack of awareness of their substantive content. Moreover, multiple levels of guidance risk producing confusing or conflicting accounts. This is further compounded by the view that the law is not well known, and probably even less well understood, by the medical profession. Taking these features into account, it is important that health care professionals become familiar with the standards of information disclosure required within their professional guidance together with how they may be held to account by such guidance in litigation proceedings.

So far I have focused upon the role of clinical guidelines in medical negligence cases. Here, I have demonstrated that clinical and professional guidance and the law intersect. An issue raised by this coming together is the extent to which there exists consistency between standards of information disclosure required in law and those expected within professional guidance. This is part of a larger question of how medical ethics and law interact. Since the law is seen as being

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the ultimate arbiter of physicians’ behaviour to be acceptable the law must be coherent. This coherence needs not only to exist internally between legal judgments in case law, but is required in relation to the professional standards of information disclosure expected of clinicians. In order to explore this point I will now consider the interplay of medical ethics and law in the context of information disclosure.

It has been recognised that the standards expected of health care professionals by their regulatory bodies may at times be higher than the minimum required by law and as such professional guidance provides a ‘gold standard to the law’s minimum’. This is because the norms for professional practice are viewed as needing to be more demanding than the minimalist requirements of the law. More recently though, the ethical standard of information disclosure has been regarded as shifting downwards towards the legal standard rather than the legal standard moving upwards to the professional standard. One of the reasons given for the law being minimalist is that in view of the consequences for failing to adhere to the law then it is important not to ‘set the bar too high’. Minimum standards, as I see them, have a tendency to mitigate against continuous improvement in professional performance by setting a lower set of criteria from which to judge conduct. Although, in practical terms, a set of minimal standards gives a bar, albeit a lower one, which clinicians need to reach. Yet, this seems incongruent with the stated aim of much of the rhetoric within health care of patients becoming central as partners in their own care and driving up choice and standards. Later in this thesis I will return to the subject of the level of consistency between professional guidance and the law and argue that there

274 For examples of this see DH, NHS Constitution for England (London: DH, 2013); DH, Liberating the NHS: No decision about me, without me. Further consultation on proposals to decision-making (London: DH, 2012).
needs to be consistency between the guidance set by law and that set by professional standards, specifically in relation to information disclosure. This is because the very essence of providing this communication is to give information to patients and as such the patient needs to know what standard of information disclosure they can expect. Moreover, a wider point is more significant here. It has been argued that medical law and medical ethics have, at times, effectively cancelled each other out, leaving a regulatory vacuum to be filled by the conscience of individual practitioners. In order to avoid this there needs to be coherence between those governing the standards of information disclosure required by health care professionals in the ethical, professional and legal arenas.

4.2 Interaction between the disciplines

In the previous section I argued for a level of consistency within legal and professional guidance governing standards of information disclosure. In order to achieve this aim analysis is required regarding how those representing the legal, ethical and clinical disciplines interact and the role of such a dialogue. The interplay between the law and medicine has been considered in relation to establishing a discourse between legislators, the judiciary, health care lawyers and the medical profession and in relation to considering the moral legitimacy

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of the law.278 In the context of establishing clarity in relation to standards of information disclosure, providing a mechanism for the different spheres of influence to communicate could contribute to a more coherent approach. This conversation could also be used to dissect areas of ambiguity in the law. Principally, in relation to the research questions contained in this thesis a multi-disciplinary approach would be valuable in providing clarity in establishing the validity of therapeutic privilege in English law together with identifying how a legal duty of candour could most effectively be enshrined in law.

In advocating a greater level of communication between representatives of the medical profession and the legal establishment, one must be cautious that the fascination of the ethical and policy dimensions of medical law do not result in neglect of engaging in the complexity of hard legal debate.279 In advancing the case for the import of proper legal analysis a positive step forward relates to growing willingness of the courts to provide a more critical approach in challenging clinicians280 and the expectation that expert testimony stands up to judicial scrutiny.281 In relation to information disclosure a key point should remain in the forefront of the minds of those developing this interdisciplinary approach - that decisions regarding the law in relation to information disclosure has real consequences for patients. These implications relate to the standard of information disclosure a patient can expect, the terms on which any exceptions to this disclosure rest, the extent to which there exist legal obligations to disclose and the legal avenues for remedy in cases where disclosure was remiss.

281 M. Hartwell, ‘Medical negligence: Can doctors and nurses still rely on the doctrine that they know best?’ Legal Medicine. 7 (2005): 293-298.
4.3 The value of fiduciary principles in addressing trust as a legal concept

In focusing upon information disclosure with patients this thesis has considered, from a legal perspective, the validity of withholding information from patients both in a general sense and in the context of medical errors. It has established the need for specific development of the legal devices of therapeutic privilege and a duty of candour in order to help protect the possibility for the patient to make autonomous decisions based upon the fullest possible information. In setting the context for this thesis I argued that autonomous decisions by patients are more likely to be fostered if communication between health care professionals and patients occurs in a relationship of trust. This brings to the fore a significant issue, that of a legal evaluation of the concept of trust within the relationship between the patient and the health care professional. So far I have confined myself to exploring this subject from an ethical and professional perspective. This reflection revealed two major strands of thought: that trust is integral to the clinician-patient relationship\(^\text{282}\) and that health care professionals are generally respected for their honesty.\(^\text{283}\) Given that there remain questions as to the extent that this trust is warranted\(^\text{284}\) and the effects of a lack of trust\(^\text{285}\) the issue of trust in the health care context now needs to be examined from a


legal perspective. Herein lies the rub, despite there being an important area of law, that of fiduciary law, which could be martialled to contribute to this debate in the English legal context, this remains somewhat of a limited conversation. In the following section I will confirm the current position of English law. I argue that this stance fails to embrace fiduciary relationships within healthcare, representing a missed opportunity to dissect how this area of law can be applied within health care relationships and thus how trust could be addressed legally. Evaluating the concept of trust in the context of fiduciary relationships is important and useful as it provides an exposition of an under-examined feature of English law which has the potential to contribute to a fuller understanding of the nature of the disclosure obligations incumbent on health care professionals.

The notion of a fiduciary relationship existing between doctors and patients, despite being embraced in other jurisdictions, has been rejected in English law. Yet, within academic literature the nature of the relationship between doctors and patients has been characterised by many commentators as fiduciary. That being, a relationship, inviting confidence, built upon trust acknowledging that one party holds the greater power and knowledge and

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other being relatively vulnerable. In the context of health care it is the patient who is characterised as vulnerable, as it is the health care professional that holds the experience and expert knowledge, compounded by, in most cases, the patient being ill and anxious or anxious about possibly being ill. It is this imbalance of knowledge and power which necessitates the presence of trust and, in the context of this thesis, provokes inquiry into how this trust might best be reflected legally. In the following section I provide justification for the assertion that the answer to this question lies in establishing the doctor-patient relationship as fiduciary within English law.

Despite the many doctrinal uncertainties in relation to fiduciary law establishing fiduciary relationships, legally as well as ethically, in the context of health care has several advantages. As a result of the emphasis in a fiduciary relationship, part of the doctor’s duty is to make information available to the patient that would be needed to make an informed choice on treatment. As such, the importance of disclosing information to patients is a fundamental part of this fiduciary relationship. Instituting fiduciary principles within the doctor-patient relationship places the patient in greater control of the facts without changing traditional principles of tort. The difficulties that patients are presented with in pursuing medical malpractice litigation have been

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recognised, 296 with not only accessing, but also understanding medical information being a fundamental obstacle. This issue brings the conversation directly back to one of the key areas of focus within this thesis - the nature of a legal duty of candour. Within fiduciary relationships candour is an established obligation. 297 This provides significant legal protection in that candour is inherent within fiduciary obligations and thus holds an advantage over the law of tort. This advantage is realised in that patients do not need to meet the burden of proof in relation to the required elements for an action in negligence. 298 To establish a fiduciary relationship, patients would merely need to be able to confirm their status as a patient and identify the doctor(s) concerned. An integral part of fulfilling this relationship for the doctor would be to impart information in an open and candid manner. 299 Additionally, enabling patients a legal remedy within fiduciary law avoids the obstacle for patients of proving a necessary element in relation to actions in the tort of negligence, that they sustained harm. For example, in the case of disclosure of medical treatment which has involved a mistake, even if no harm can yet be substantiated, fiduciary law provides the assurance that such information should be disclosed as part of the doctor’s fiduciary duty. 300 Failure to do so within fiduciary law provides a legal remedy for patients in the form of compensation on the grounds of a lack of candour.

A wider benefit of characterising the doctor-patient relationship as fiduciary is that it puts the particular patient with whom the relationship is formed in sharp focus emphasising this as the central partnership 301 together with underscoring

298 In brief, for an action to be successful in negligence the following are required: that a duty of care was owed, there was a breach in the duty of care and causation is established. For more detail see J. Mason and G. Laurie, Law and Medical Ethics (Oxford, Oxford University Press, 2006) p305.
the reciprocity of obligations and responsibilities for both the doctor and patient.\textsuperscript{302} It is this legal reflection of trust which prioritises the essence of the relationship as the source of legal and moral responsibilities, rather than discrete actions or events that occur within relationships.\textsuperscript{303} This moves the focus towards more positive ground, directing attention to the nature of the doctor-patient relationship and how this is reflected in law, rather than focusing on what happens when things go wrong in the patient’s care within the tort of negligence. Once the professional-patient relationship is based on an open and equal exchange of information then the parties can negotiate the next steps in their alliance and agree what actions to take.\textsuperscript{304} Certainly, characterising the doctor-patient relationship as fiduciary would underscore the importance of trust, loyalty and honesty.\textsuperscript{305} That being said, its emphasis is more than just symbolic. Indeed, increasing patients’ fiduciary trust in their doctor has been associated with improvements in getting care promptly and having health care needs met.\textsuperscript{306} This, together with the focus upon the partnership between patient and doctor and the legal protection fiduciary law affords to patients, makes it a strong candidate to accurately reflect notions of trust from a legal perspective.

4.4. Conclusion

This thesis critically analyses two particular areas of law in relation to disclosure of information with patients: therapeutic privilege and a legal duty of candour. This chapter provided an opportunity to give wider backdrop to these features of law which occupy a fairly narrow legal terrain. This dialogue elicits two main

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{302} For further discussion of the moral responsibilities of empowered patients see M. Brazier, ‘Do no harm- patients have responsibilities too?’ \textit{Cambridge Law Journal.} \textbf{65} (2) (2006): 397-422.
\end{itemize}
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conclusions. Firstly, progress has been made in terms of the law’s employment of clinical and professional guidelines together with a greater judicial readiness to scrutinise clinical practice. Given the very real impact of decisions regarding the legal and professional standard of information disclosure for patients a fundamental part of providing clarity requires consistency between professional and legal standards of disclosure. Secondly, the rejection of fiduciary principles within the doctor-patient relationship in English law represents a missed opportunity to develop a legal counterpart to notions of trust and loyalty within health care law.

In the following chapter I will open the substantive part of the thesis by focusing on the exception to disclosure norms which is provided by the legal device of therapeutic privilege. This exploration provides a foundation for establishing the legal standard of disclosure and the ethical and legal validity of therapeutic privilege.
Chapter Five
The need to know - therapeutic privilege: a way forward

5.1 Abstract

Providing patients with information is fundamental to respecting autonomy. However, there may be circumstances when information may be withheld to prevent serious harm to the patient, a concept referred to as therapeutic privilege. This paper provides an analysis of the ethical, legal and professional considerations which impact on a decision to withhold information that, in normal circumstances, would be given to the patient. It considers the status of the therapeutic privilege in English case law and concludes that, while reference is made to circumstances when information (primarily in relation to risk disclosure) may be withheld, further clarification is required on the status of therapeutic privilege. I suggest there has been shift in English law relating to the standard of information disclosure towards one set by the test of the reasonable, prudent patient. It is this shift that necessitates the existence of a therapeutic privilege which enables doctors to withhold information that would usually be given to the patient in order to prevent serious harm. I then explore the professional guidance in relation to information disclosure and how this relates to the legal position. There are strong ethical arguments in favour of disclosure of information to patients. In light of these, further clarification is required to identify and define the grounds on which this exception exists, the information that could lawfully be withheld and how this exception extends to rest of the health care team, particularly nurses. As such, explicit ethical and legal scrutiny of therapeutic privilege is needed in order to consider how this concept might be articulated, constrained and regulated.

5.2 Keywords

Doctor-patient relationship; Health care team; Information disclosure; Therapeutic privilege; Truth-telling.
5.3 Introduction

‘The relationship of information disclosure to the standard of medical care has been, and still is, perhaps the major focus of developing medical law’.\(^{307}\) The communication of information is a well-recognised and essential part of the relationship between the doctor and patient. It is also central to the process of obtaining consent. For some patients, it has been suggested that it may not be appropriate to disclose particular information due to the need to avoid the potential distress and harm that may result. This exception has been termed ‘therapeutic privilege’ and refers to withholding information from the patient which is considered to be a potential danger to the patient’s well-being.\(^{308}\) Information is withheld during the consent process in the belief that its disclosure would lead to harm or suffering of the patient.\(^{309}\) Thus, information a competent patient would ordinarily be told is deliberately withheld for the patient’s benefit, as it is perceived by the doctor.\(^{310}\) However, as Brazier and Cave\(^{311}\) suggest, ‘this defence needs to be based on cogent reasons relating to the welfare of that particular patient’.

This paper provides an analysis of the ethical, legal and professional considerations impacting on decisions made by doctors to withhold information from their patients. Firstly, I outline the ethical arguments in favour of therapeutic privilege. This is a controversial area; since many consider that anything less than the standard of disclosure required by law as an example of unacceptable paternalism. This opinion is perhaps unsurprising given the prominence of patient autonomy within contemporary health care. However, like many controversial subjects it requires further consideration of when, and if, this practice can be ethically and legally justified. Secondly, I consider the status of


\(^{311}\) M. Brazier and E. Cave, Medicine, Patients and the Law (London: Penguin, 2007) p118.
therapeutic privilege in English case law. I conclude that, while reference is made to therapeutic privilege and its use in other jurisdictions further explicit consideration is required to examine the limits of such a privilege, the circumstances in which it could validly be invoked and to whom does the privilege extend within the health care team. I suggest that there has been shift in English law to the standard of information disclosure set by the test of the reasonable, prudent patient. It is this shift that necessitates the development of therapeutic privilege in English case law. However, there are powerful ethical arguments in favour of disclosure of information to patients. Given the strength of these arguments further ethical and legal scrutiny of therapeutic privilege is required in order to ensure that it is narrowly defined, used appropriately and is consistent with legal and professional guidance. This further articulation of therapeutic privilege could be achieved through consultation between the judiciary, the medical profession and patient group representatives to produce clear guidance on its use.

5.4 The ethical justifications for therapeutic privilege

Whilst the notion of withholding information from competent patients is controversial in contemporary health care, an analysis of therapeutic privilege demands consideration of the relative weight of ethical justifications in favour of its use. Several authors have explored the moral reasoning involved in considering difficult ethical judgements regarding the validity of the use of therapeutic privilege. In doing so they have identified processes which may help to establish whether deceiving the patient may be morally permissible. Furthermore, empirical studies have examined doctors’ attitudes towards the use


of deception in clinical practice. There are various philosophical concepts related to the notion of information disclosure. These include truth-telling, concealment, telling half-truths and withholding information. Whilst it is beyond the scope of this paper to analyse each of these terms it is important to recognise that, in practice, sometimes the boundaries of these concepts are blurred and there may be differing moral distinctions and interpretations of each. The most common and perhaps the strongest reason for not telling the truth is to protect others from harm - to protect patients from harm or distress. This perception of harm might even extend to the effects of a loss of hope. There may also be concerns that the patient might refuse to continue with therapy once they are given particular information. In addition, given the individual nature of patients and the complexities of care, some argue that an absolutist approach to truth-telling is not often helpful in the health care setting. This supports the need for an exception to information disclosure which the doctor could invoke without professional and legal censure in cases when the patient is at serious risk of harm from disclosure. Examples of this type of harm might include psychological and emotional harm which affects the patient’s physical condition and ability to make decisions. Maclean identifies that, in principle, therapeutic privilege ‘should only apply to situations where disclosure would harm the patient or make them so distressed that a rational decision is no longer possible’. It is useful to think of the clinical setting and how these principles within information disclosure may operate in practice. Brazier and Cave consider a possible clinical scenario and question whether a defendant surgeon might be able to rely on a defence of therapeutic privilege. They ask, in relation to a very elderly patient who the surgeon failed to warn of a small risk of impotence, whether this could be justified by saying, ‘the patient is highly nervous and exaggerates risks.

315 For further discussion of the related concepts to the notions of information disclosure and definitions of each of these terms see S. Bok, Lying: Moral Choice in Public and Private Life (New York: Vintage Books, 1999) and J. Jackson, Truth, Trust and Medicine (London: Routledge, 2001) in particular see Chapter 7 ‘Deceptions and concealments in medical and nursing practice’ p94.
If he does not have the surgery he will be doubly incontinent and have to go into a home. I just don’t think he could cope with the information.\textsuperscript{319} Of course, it would be for the court to decide whether, given the circumstances of the case, this subjective, professional judgement of the surgeon could be justified and the use of therapeutic privilege supported. Notwithstanding the clinical situation, when therapeutic privilege is considered it should only apply to ‘specific items selected by the doctor for specific reasons’.\textsuperscript{320} Therefore, it is limited to that particular patient and their individual circumstances. Although the content of information itself is important, further consideration also needs to be given as to how that information can be conveyed. The manner by which information is disclosed to patients and ensuring good practice within this communication process is vital. The doctor must critically reflect whether all possible steps have been taken to consider how the information could be given to the patient in order to minimise and avoid any potential serious distress and harm.

Issues surrounding information disclosure exist within a wider context of the doctor-patient relationship. Within this there may be potential tension between the doctor’s duty of disclosure and obligation to act in the patient’s best interests. The duty to act in the best interests of patients, including doing no harm, may validate withholding information. Indeed, determining what information might be in a patient’s best interests to disclose, or when there may be circumstances when withholding particular information might be more favourable, could be viewed as part of the doctor’s duty to exercise clinical judgement. Doctors have to balance an obligation to provide information to patients with the knowledge that it may cause severe distress, anxiety and harm. So whilst honesty is generally desirable, it might not always be the best policy. This is because the duty to tell the truth is not absolute and can be outweighed by other moral considerations such as the obligation not to cause great and avoidable harm.\textsuperscript{321} However, it has been recognised that both those for and against information disclosure, in cases where therapeutic privilege may be relevant, appeal to a

\textsuperscript{319} M. Brazier and E. Cave, \textit{Medicine, Patients and the Law} (London: Penguin, 2007) p118.
\textsuperscript{320} J. Mason and G. Laurie, \textit{Mason & McCall Smith’s Law and Medical Ethics} (Oxford: Oxford University Press, 2006) p398.
‘harm-benefit’ calculus to support their position.\textsuperscript{322} The practice of withholding relevant information from patients without their knowledge or consent creates a conflict between concurrent obligations to protect patients and promote their welfare with parallel obligations to be truthful and provide relevant information, thus respecting a patient’s autonomy.\textsuperscript{323} However, in extreme examples this potential harm to patients may be considered as so serious that it provides the moral justification to support withholding that information. This position has proved controversial and has led to analysis of the arguments given for restricting information disclosure.\textsuperscript{324}

Much has been written on the topics of beneficence, autonomy and paternalism and how each if these concepts interact, alongside their philosophical underpinnings. Each of these issues are relevant when considering why philosophically the issue of information disclosure, and any exceptions to it, is one which the law should address. Here, I do not intend to attempt to capture these arguments as this paper is focused more narrowly on legal and professional perspectives of information disclosure. I hope merely to identify the relevance of these philosophical issues to the issue of therapeutic privilege. The principle of beneficence, the duty to act to benefit the patient, is key within any justification of therapeutic privilege. Maclean identifies that, ‘although the obligation to benefit the patient seems intuitively a good thing, it is important to determine the limits of the duty and consider how it interacts with the obligation to respect autonomy’.\textsuperscript{325} Thus, in withholding information the doctor needs to consider how this affects the patient’s autonomy. A related concept, paternalism, is also relevant to therapeutic privilege. Beauchamp and Childress define paternalism as, ‘the intentional overriding of one person’s known preferences or

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\item[] \textsuperscript{322} \textit{Ibid.}, p2.
\item[] \textsuperscript{325} A. Maclean, \textit{Autonomy, Informed Consent and Medical Law} (Cambridge: Cambridge University Press, 2009) p49.
\end{itemize}
actions by another person, where the person who overrides justifies the action by the goal of benefitting or avoiding harm to the person whose preferences or actions are overridden.\textsuperscript{326} They go on to discuss withholding of information in the context of ‘justified strong paternalism’ listing the conditions which would need to be satisfied for it to be viewed as such.\textsuperscript{327} They identify the problem of medical paternalism as that of ‘rightly specifying and balancing physician beneficence and patient autonomy in the patient-physician’ relationship’.\textsuperscript{328} Taking into account the different obligations that doctors owe their patients in terms of respecting autonomy and acting in the patient’s best interests is complex and requires the use of professional judgement. Consequently, any decision to withhold information on the grounds of therapeutic privilege requires the doctor to consider the ethical underpinning of his actions in addition to the required professional and legal standards of practice.

5.5 The legal position

The standard of information disclosure required by English law to obtain consent was considered in \textit{Chatterton v Gerson and another}.\textsuperscript{329} Here, as long as ‘the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass’.\textsuperscript{330} This underscored the distinction between treatment given in the absence of any consent which would be dealt with as a battery, and consent given on the basis of inadequate information which would have its remedy in negligence.\textsuperscript{331} Alongside this, a doctor is required as part of his duty of care to his patient to warn the patient if there is ‘a real risk of misfortune

\begin{footnotesize}
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\textsuperscript{327} \textit{Ibid.} p186. \\
\textsuperscript{328} \textit{Ibid.} p187. Although Beauchamp and Childress caution that justifying paternalistic actions by assigning an overriding status to either respect for autonomy or beneficence is overly simplistic and can be seriously misleading p187. \\
\textsuperscript{329} \textit{Chatterton v Gerson and another} [1981] 1 All ER 257. \\
\textsuperscript{330} \textit{Ibid.} para 265 as per Mr Justice Bristow. \\
\textsuperscript{331} \textit{Ibid} para 265 as per Mr Justice Bristow who emphasised that ‘if the information is withheld in bad faith, the consent will be vitiating by fraud’.
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inherent in the procedure, however well it was carried out’. Albeit obiter, these comments introduced the important question of how to define risk which is material to the patient.

The House of Lords considered the standard by which a doctor should be judged when warning his patient of risks in *Sidaway*. The majority opinion confirmed the *Bolam* standard as the test of a doctor’s duty to warn the patient of risks, requiring the doctor to act in accordance with practice accepted by a responsible body of medical opinion. Lord Scarman dissented from this view suggesting that the standard of information disclosure should be assessed by reference to what the objective, reasonable, prudent patient would wish to know. He disagreed with the extension of the *Bolam* test from decisions relating to diagnosis or treatment, to decisions regarding risk disclosure. In his view, the patient’s right to make his own decision was viewed as a basic human right. The standard for risk disclosure should not be what the medical professional thinks is appropriate, but what the average, prudent patient would want to know. A doctor would therefore be liable if he omitted to inform a patient of a risk which, in the court’s view, was such that a prudent person in the patient’s situation would have regarded it as significant. However, Lord Scarman acknowledged the role of therapeutic privilege and he cited, with approval, the American case of *Canterbury v Spence*. As defined by that case, therapeutic privilege enables a doctor to withhold information from his patient regarding risk if it can be shown that a reasonable medical assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient. Lord Scarman argued that it is,

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332 *Chatterton v Gerson and another* [1981] 1 All ER 257 per Mr Justice Bristow at 258.

333 *Sidaway v Bethlem Royal Hospital Governors and Others* [1985] 1 All E.R. 643.

334 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

335 *Sidaway v Bethlem Royal Hospital Governors and Others* [1985] 1 All E.R. 643 per Lord Scarman at 649.


337 *Ibid*.


339 *Ibid*. 

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'plainly right that a doctor may avoid liability for failure to warn of a material risk if he can show that he reasonably believed that communication to the patient of the existence of the risk would be detrimental to the health (including of course, the mental health) of his patient'. 340

This plea for the prudent patient standard, subject to a therapeutic privilege ‘exception’, was not followed by Lord Scarman’s fellow judges. Though there was no further explicit reference of therapeutic privilege, there was an acknowledgement that there may be circumstances when information that would normally be disclosed by a doctor in the exercise of his responsible clinical skill, may be withheld. Lord Templeman recognised, for example, that the obligations relating to information disclosure should be weighed between, on the one hand, having regard to the best interests of the patient and, on the other, making sure sufficient information is available to the patient in order to reach a balanced judgement. 341 He confirmed that it was up to the doctor to make use of his training, knowledge, and experience to decide what and how that information is disclosed. A doctor may therefore take the position that the patient may be confused, frightened, or misled by more detailed information which he was unable to evaluate at a time when he is suffering from stress, pain, and anxiety. 342 In his view,

‘the doctor impliedly contracts to provide information which is adequate to enable the patient to reach a balanced judgement, subject always to the doctor’s own obligation to say and do nothing which the doctor is satisfied will be harmful to the patient’. 343

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340 Sidaway v Bethlem Royal Hospital Governors and Others [1985] 1 All E.R. 643 per Lord Scarman at 654.
341 Ibid. para 666 as per Lord Templeman.
342 Ibid. para 664 as per Lord Templeman.
343 Ibid. para 666 as per Lord Templeman. Interestingly, Mr Justice Rougier in McCallister v Lewisham and North Southwark Health Authority and Others [1994] 5 Med LR 343 repeats this passage of Lord Templeman’s and refers to this as therapeutic privilege. He goes onto define this as a situation where, ‘a doctor may be genuinely and reasonably so convinced that a particular operation is in the patients best interests that he is justified in being somewhat economical with the truth where recital of dangers are concerned’ per Mr Justice Rougier.
Lord Bridge considered the role of medical evidence and acknowledged a patient’s right to be informed about risk. He accepted that this was subject to an important qualification: that the ‘degree of disclosure of risk is best calculated to assist a particular patient to make a rational choice whether or not to undergo a particular treatment must primarily be a matter of clinical judgement’.  

The topic of information disclosure in relation to risk was examined again in *Pearce*. In a judgement described as a ‘radical departure from a reasonable doctor test’, Lord Woolf found that,

‘if there is significant risk which would affect the judgement of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if that information is needed so that the patient can determine for him or herself as to what course he or she should adopt’.  

Jones considers the influence of the apparent combination of a prudent patient standard with a reasonable doctor standard of disclosure in *Pearce*. Recognising the role of judicial scrutiny of what a reasonable doctor ought to disclose he notes that this ruling could effectively introduce a prudent patient standard.

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 Sidaway v Bethlem Royal Hospital Governors and Others [1985] 1 All E.R. 643 para 662 as per Lord Bridge. Lord Bridge did, however, make the case for the role of judicial intervention in this process. Ruling in favour of the professional standard of information disclosure Lord Bridge entered an important caveat, ‘[a] judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonable prudent medical man would fail to make it’ para 663. However, in M. Jones, ‘Informed consent and other fairy stories’, *Medical Law Review*. 7 (1999): 103-134, he identifies that the difficulty has been that there are very few instances where a court has been willing to do this at 116. One example of such an instance is *McCallister v Lewisham and North Southwark Health Authority and Others* [1994] 5 Med LR 343.


 This willingness to assess and challenge the medical profession has been analysed by Lord Woolf in Lord Woolf, ‘Are the courts excessively deferential to the medical profession?’ *Medical Law Review*. 9 (2001): 1-16.
standard into English law. Therefore, on one view, it might appear that doctors are now under a duty to disclose all the significant risks that a reasonable patient would want to know in the circumstances. However, the impact of Pearce seems unclear. McLean cautions that even if the Bolam test is weakened by Pearce - as it seems to add an additional caveat to the routine acceptance of the professional standard - its actual impact is not clear. Lord Woolf introduced a qualification that,

‘the doctor, in determining what to tell a patient, has to take into account all the relevant considerations, which include the ability of the patient to comprehend what he has to say to him or her and the state of the patient at that particular time, both from the physical point of view and an emotional point of view’.  

His judgment would seem to offer an implicit acknowledgement that there may be particular circumstances in which it may not be appropriate to disclose certain information to the patient.

In 2004, in AB and others v Leeds Teaching Hospital NHS Trust and another the subject of disclosure moved away from information regarding relative risks. In this case, the question turned on the provision of information to bereaved parents in relation to their deceased child’s post-mortem. Mr Justice Cage acknowledged that there may be circumstances in which a clinician might be justified in withholding details of a post-mortem from parents. He found the ‘blanket policy’ of withholding of information unacceptable, even if the reason given for this was to avoid further distress to the grieving parents of a deceased child. He qualified this, however, by emphasising the need for doctors to use

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353 AB and Others v Leeds Teaching Hospital NHS Trust and Another [2004] 3 FCR 324.
354 Ibid. para 327 as per Mr Justice Cage.
their judgement, on a case-by-case basis.\textsuperscript{355} Summing up this judgement he ruled that the,

‘evidence of the previous blanket practice, carried out by virtually all clinicians, had not appeared to have been exercised on a case-by-case basis, giving consideration to whether the information would be distressing to individual parents and families. The practice could, as such, not be justified and was negligent’. \textsuperscript{356}

In the same year, the House of Lords considered the case of \textit{Chester v Afshar}.\textsuperscript{357} There was consensus that a legal duty is owed to patients to warn, in general terms, of possible serious risks in a procedure. Although obiter, Lord Steyn noted that ‘there may be wholly exceptional cases where objectively in the best interests of the patient the surgeon may be excused from giving a warning’.\textsuperscript{358} This recognises that there may be circumstances, albeit exceptional ones, when information might be withheld from the patient. Yet, it will be for the Court to decide on the legitimacy or otherwise of the decision to withhold information.

Reviewing this body of law as a whole, there is acknowledgement that there may be circumstances, however rare, when information may be withheld from a competent patient in order to protect him from serious harm. This is justified by the obligation to act in the patient’s best interests. Further to this, the judiciary has (so far) appeared reluctant to create a legal precedent which would bind the decisions of courts or doctors in unknown, future circumstances. Thus, there continues to exist references to exceptions, albeit rare ones, within the general rules of disclosure.

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\item \textsuperscript{355} \textit{Ibid.} para 389 as per Mr Justice Cage.
\item \textsuperscript{356} \textit{Ibid.} para 327 as per Mr Justice Cage.
\item \textsuperscript{357} \textit{Chester v Afshar} \textsuperscript{[2004]} UKHL 41.
\item \textsuperscript{358} \textit{Ibid.} para 16 as per Lord Steyn.
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### 5.6 A shift in the standard of information disclosure

There has been debate in the medico-legal literature as to the extent to which the prudent patient standard of information disclosure has superseded the professional standard. Whilst Brazier and Miola\(^ {359} \) agree that *Pearce* endorses the prudent patient standard and Mason and Brodie recognise, ‘for the first time, therefore, Lord Woolf introduced the reasonable patient standard of information disclosure as an acceptable part of English medical jurisprudence, and we suggest that this has been of considerable importance’\(^ {360} \) others, such as Maclean, offer a less favourable assessment of its acceptance in English law.\(^ {361} \)

At the very least, it may be argued, that there has been a shift towards further recognition of the reasonable patient standard of information disclosure. This is evidenced by the recognition of the reasonable patient standard of information disclosure in *Pearce* and that of informed consent in *Chester v Afshar*.\(^ {362} \) When the standard of information disclosure is judged using the professional standard test, decisions of information disclosure are firmly within the remit of medical expertise. Traditionally, as long as a doctor has acted in ‘accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act’\(^ {363} \) who can provide a ‘logical analysis’\(^ {364} \) of the reasons behind their decision then the doctor will not be found liable in negligence. In essence, the patient is entitled to be given as much information as a responsible body of medical opinion determines to be acceptable (taking into account judicial scrutiny). However, within the prudent patient test, the standard of disclosure is judged primarily by what the objective, reasonable patient would wish to know.\(^ {365} \)

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\(^{361}\) A. Maclean, The doctrine of informed consent; does it exist and has it crossed the Atlantic?’ *Legal Studies* 24 (3) (2006): 386-413.

\(^{362}\) However, S. Devaney, ‘Autonomy rules ok’, *Medical Law Review* 13 (1) (2005): 102-107 comments on *Chester v Afshar* and notes that this ‘case has not altered the duties of surgeons’ at 104 and ‘the responsibilities of the courts and doctors remain the same as they ever were’ at 107.

\(^{363}\) *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582 para 587 as per Mr Justice McNair.

\(^{364}\) *Bolitho v City Hackney Health Authority* [1997] 39 B.L.M.R. para 243 as per Lord Browne-Wilkinson.

\(^{365}\) For a discussion of the criticisms of this test (along with the criticisms of the professional standard of information disclosure) see E. Jackson, ‘Treatment and the impotence of tort’.
This distinction between the professional standard of information disclosure and that expected within the reasonable, prudent patient standard is central to the need to subject therapeutic privilege to distinct and explicit legal analysis. Within the purely professional standard, the decision to withhold information would have been considered as part of the doctor exercising their clinical skill. Whereas, the prudent patient standard focuses on the information that the patient would wish to be given. Yet, there might be circumstances when the doctor has grave concerns about the impact of this information. As a result, there needs to be some legal mechanism to determine whether withholding the information is lawful. Jackson identifies that in jurisdictions which have adopted the ‘prudent patient’ test, this test has been subject to an exception, known as therapeutic privilege. She describes this exception as a suspension of the doctor’s duty to provide the patient with material information, if in the doctor’s judgement it would be likely to cause this patient harm, such as severe distress and anxiety. Moreover, McLean and Mason also recognise that even the prudent patient standard allows for non-disclosure of certain information based on therapeutic privilege.

This raises questions as to whether the concept of therapeutic privilege is required in law. Lord Scarman believed this was the case. In Sidaway he identified that the need for therapeutic privilege within a prudent patient test stems from the fact that the prudent patient is not a real person, and certainly not the patient himself. Thus, Lord Scarman considered the existence of a need that, ‘the doctor should have the opportunity of proving that he reasonably believed that disclosure of risk would be damaging to his patient or contrary to his best interest’. So, if therapeutic privilege is established, then there is no breach of the duty to inform the patient of the particular information that may cause the harm. The extent to which the development of therapeutic privilege as a result

\[\text{367 Ibid. p281.}\]
\[\text{369 Sidaway v Bethlem Royal Hospital Governors and Others [1985] 1 All E.R. 643 para 654 as per Lord Scarman.}\]
from a move towards a prudent patient standard of information disclosure is justified and how it should be regulated requires further consideration. An appropriate starting point might be provided by looking towards jurisdictions which already operate a prudent patient standard of information disclosure.

5.7 International jurisdictions

In 1972, the classic formulation of the reasonable, prudent, patient standard of information disclosure was provided in the American case of *Canterbury v Spence*. The court recognised that, ‘patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder treatment, or perhaps even pose psychological damage to the patient’. Conditions were placed on the use of this privilege to keep information from the patient. Sound medical judgement is required in order to assess that the communication of the risk would present a threat to the patient’s well-being. Furthermore, it was emphasised that, ‘the privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs’. The burden of proof for the appropriate use of this privilege rests upon the doctor. This stems from the patient’s *prima facie* right to be informed and because it is usually the doctor who can provide evidence to support the use of this privilege.

This judgement reveals the relationship between the archetypal notion of the reasonable prudent patient standard of information disclosure and the need for an exception based upon this formulation. Accordingly, when determining what the objective reasonable patient would wish to know, in particular circumstances, the doctor has the opportunity to invoke therapeutic privilege. This is based on the belief by the doctor that if the particular information is disclosed to the patient it will cause serious harm. However, one of the difficulties is that the precise

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371 *Ibid.* para 48 as per Mr Justice Robinson.
372 *Ibid.* para 49 as per Mr Justice Robinson.
formulation of therapeutic privilege varies amongst jurisdictions. Faden et al.\textsuperscript{373} discuss the various formulations of the concept. Framing it broadly, a doctor would be permitted to withhold information if disclosure would result in any deterioration, however minor in the physical, psychological or emotional condition of the patient. Taking a narrower view of the concept, which Faden et al. associate with the view taken in Canterbury, would mean the doctor being permitted to withhold information only in circumstances when the patient’s knowledge of that information would have ‘serious health related consequences - for example, by jeopardising the success of treatment or harming the patient psychologically by critically impairing relevant decision-making processes’.\textsuperscript{374} They also identify a further, even narrower definition in which therapeutic privilege can be invoked if, ‘the physician reasonably believes disclosure would render the patient incompetent to consent to or refuse treatment, that is, render the decision non-autonomous’.\textsuperscript{375}

Another case which the expounded the reasonable prudent patient standard of information disclosure was \textit{Reibl v Hughes}.\textsuperscript{376} In this case the Supreme Court of Canada rejected handing ‘over to the medical profession the entire question of the duty of disclosure’.\textsuperscript{377} The court preferred the objective standard of information disclosure. Within this ruling there was a recognition that,

‘it may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment and the doctor may, in such a case, be justified in withholding or generalizing information as to which he would otherwise be required to be more specific’.\textsuperscript{378}

So, within the Canadian approach to the reasonable prudent patient standard there is an acknowledgement of an exception to information disclosure.

\textsuperscript{374} \textit{Ibid.} p37.
\textsuperscript{375} \textit{Ibid.}
\textsuperscript{376} \textit{Reibl v Hughes} [1980] 2 S.C.R. 880.
\textsuperscript{377} \textit{Ibid.} para 882 as per Chief Justice of Canada.
\textsuperscript{378} \textit{Ibid.} para 895 as per Chief Justice of Canada.
The High Court of Australia firmly rejected the application of the professional standard of disclosure based on the *Bolam* test to cases in relation to risk disclosure in *Rogers v Whitaker*. Here, the standard of information disclosure and within this the duty to warn the patient of the risks inherent in the proposed treatment was articulated. In a joint ruling a risk was said to be material if it,

‘is one to which a reasonable person, in the position of the plaintiff, would be likely to attach significance, or one which the medical practitioner is or should be reasonably aware that the particular patient, if warned of the risk, would probably find significant’.  

Several commentators have provided analysis of the rejection of the *Bolam* test in this context and the implications of this judgement. The emphasis was placed on the patient’s right to make a meaningful choice which becomes, ‘meaningless unless it is made on the basis of relevant information and advice’. The court recognised that there may be exceptional cases in which a particular patient may be harmed by the disclosure of information. The doctor’s duty to disclose was subject to therapeutic privilege. Thus, if there is, ‘particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient’ the doctor will not fall below the appropriate standard of care if he withholds this information. Again, the concept of therapeutic privilege, albeit with limitations on its scope, is recognised within a jurisdiction which has firmly rejected the professional standard of information disclosure.

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disclosure in favour of a standard which incorporates the reasonable, prudent patient standard.

5.8 The need for clarity

It is acknowledged by both the medical profession and the judiciary that there are circumstances – which may be few and far between - when information may be withheld from a patient to prevent ‘serious harm’. In the case of the professional standard of information disclosure, it is clearly the profession itself which sets the standard for disclosure. As the standard of disclosure moves from a professional standard to one measured by reference to the prudent patient, this ‘privilege’ afforded to doctors needs to be articulated further. This is because within the professional standard of information disclosure there is an allowance for the clinical judgement of the doctor. As such, although he would have to justify withholding information that would usually be disclosed, this could be done within the remit of his professional judgement, a separate privilege would not be required. However, the perspective has altered under a standard of disclosure that is judged by reference to the prudent patient. Therefore, a privilege is required in order for the doctor to withhold information that would usually be disclosed to the patient. However, given the controversial nature of therapeutic privilege and how its use might impact on patient autonomy further consideration is required on the limits of such a privilege.

One approach might be a more formal articulation of ‘therapeutic privilege’ in English law. However, as Tickner recognises, the doctor’s therapeutic privilege would need to be carefully defined. She argues that ‘unless it is limited to situations in which the patient has an exceptional medical problem taking him outside the position of an ordinary patient nervous about his health and treatment, the privilege could too easily be utilised to evade the court’s scrutiny’. Other commentators take a different view arguing that therapeutic privilege is already part of English case law. Jones believes that ‘under English

385 Ibid.
law the notion of therapeutic privilege is not part of a defence to a claim for non-disclosure, it is incorporated within the duty of disclosure itself, applying *Sidaway*.\footnote{M. Jones, ‘Informed consent and other fairy stories’, *Medical Law Review*. 7 (1999): 103-134 at 113.} He cautions that ‘a clear danger that an “exception” to disclosure on the basis of the potential for inducing anxiety in a patient could be used to undermine the patient’s right to exercise a choice about whether to accept treatment’.\footnote{Ibid.} Maclean\footnote{A. Maclean, *Autonomy, Informed Consent and Medical Law* (Cambridge: Cambridge University Press, 2009) p404.} acknowledges that therapeutic privilege is as applicable under the professional standard as it is under a standard of disclosure compatible with a doctrine of informed consent. Discussing this point in his book, ‘*Autonomy, Informed Consent and the Law*’, Maclean reaffirms this point and underscores that the professional standard of information disclosure can be used to assess the validity of withholding information in English law.\footnote{Ibid. p183.} This opinion appears to be based on the arguments contained in Lord Templeman’s judgement in *Sidaway*.\footnote{*Sidaway v Bethlem Royal Hospital Governors and Others* [1985] 1 All E.R. 643.} Certainly, there is acknowledgement within *Sidaway* and subsequent cases\footnote{\cite{Pearce and Another v United Bristol Health Care NHS Trust [1998] 47 BMLR 118; Chester v Afshar [2004] UKHL 41; AB and Others v Leeds Teaching Hospital NHS Trust and Another [2004] 3 FCR 324.} of exceptional circumstances when information might be withheld from patients to prevent serious harm - which is consistent with acting in their best interests. Despite this general agreement of circumstances when information might be lawfully withheld from patients, there is no explicit consensus on whether therapeutic privilege exists in English case law and a lack of clarity on its limits. Indeed, Berg at al\footnote{J. Berg, P. Appelbaum, C. Lidz, L. Parker, *Informed Consent: Legal theory and clinical practice* (Oxford: Oxford University Press 2001) p80.} caution in their discussion of therapeutic privilege in relation to informed consent that ‘if the scope of therapeutic privilege is not severely circumscribed, it contains the potential to swallow the general obligation of disclosure’. It seems though that given the emphasis placed on patient autonomy in subsequent cases such as *Chester v Afshar*\footnote{*Chester v Afshar* [2004] UKHL 41.} the decision on the validity to withhold information has been somewhat wrestled out of the hands of the medical profession. It is for the court to decide on the legitimacy to withhold information, as Lord Steyn declared, ‘in modern
law, paternalism no longer rules’.\footnote{Ibid. para 16 as per Lord Steyn.} Despite this, there is the view that since Sidaway therapeutic privilege has continued to find favour with the judiciary.\footnote{K. Veitch, The Jurisdiction of Medical Law (Farnham: Ashgate, 2007) p98.}

5.9 Ambiguity of therapeutic privilege

There appears to be at least three areas of ambiguity within the legal concept of therapeutic privilege. Firstly, there are difficulties in defining a future ‘serious harm’. Secondly, there is ambiguity as to whether therapeutic privilege extends to the rest of the health care team and, in particular, to nurses. Thirdly, clarification is required in relation to any extension of therapeutic privilege to withholding information in areas other than risk disclosure, such as diagnosis or prognosis.

5.10 Defining a future ‘serious harm’

As has been discussed, in order for therapeutic privilege to be valid, information that would usually be given to a competent patient is withheld in order to protect the patient from serious harm. The very nature of the requirement of therapeutic privilege to prevent a serious harm to the patient has several difficulties. Predicting the future and what might be a possible reaction by the patient to an element of information is hazardous. The doctor would have to rely on his training, knowledge and experience to make a professional judgement on that particular patient’s circumstances. Although these elements are useful in making any decisions they are not infallible, particularly when the decision is in relation to another person’s reactions which might be based on a different value system.

The courts have attempted to limit the use of therapeutic privilege by ring-fencing the concept with caveats such as ‘wholly exceptional’, ‘serious threat’, and ‘best interests’ when describing those rare cases when it would be relevant. These terms remain, perhaps intentionally, subjective and difficult to define. The doctor must show that the decision is in the best interests of the patient and meets the criteria considered. Indeed, the concept of harm is multifaceted. There
are different types of harm to consider: psychological, physical, spiritual and emotional. The doctor would have to demonstrate clearly that, based on his assessment, the consequences for the patient would have been a significant enough harm that invoking therapeutic privilege was appropriate. In addition to the potential difficulties quantifying the extent of the potential harm that would be needed to qualify for therapeutic privilege the need for the decision to be specific in relation to that particular patient is important. This is because information that might cause serious harm to one patient may not harm another patient to such an extent.

5.11 Extension to the team

Could therapeutic privilege extend to the other members of the health care team and, in particular, to nurses? This question is relevant because of the closeness of the nurse-patient relationship. Arguably, nurses spend more time with patients than any other member of a multi-disciplinary health care team. Given the importance of effective communication, information disclosure is a key issue for nurses and becomes increasingly significant because of the autonomous and extended roles they now undertake. A further issue is that, as part of a multi-disciplinary model of care, headed by a doctor, there is the potential for disagreements relating to decisions regarding information disclosure. Nurses may find themselves in situations where they disagree about information being withheld from the patient by a doctor invoking therapeutic privilege. Arguably, it is the assigned most senior doctor who acts as the head of the health care team. Therefore, they would have the ultimate duty to meet the standard of information disclosure required by law. However, other members of the health care team also have corresponding legal and professional obligations. These issues merit further examination as doctors and nurses are both professionally accountable for their own practice. Professionally and legally, both owe their patient a duty of care, included within this duty are obligations to meet the legal standard of disclosure. Hence, each profession has to consider their position on therapeutic privilege. Nurses are undertaking various extended roles, many have their own caseloads and the profession is becoming increasingly autonomous. As a result,
it is relevant to consider how a privilege to date only considered in terms of the medical profession, translates into nursing practice.

In order to explore how therapeutic privilege may extend to those within the health care team further consideration is required as to whom may be named in litigation. Those named in a negligence action can include: the employer of the professional (for example, the NHS Trust or hospital) under the doctrine of vicarious liability; the individual medical professional; or the provider unit directly.\(^\text{396}\) Brazier and Cave comment that patients who bring a claim based on the alleged negligence of a nurse rarely bother to name the nurse personally as a defendant.\(^\text{397}\) Yet, as nurses take on more extended roles and manage their own caseload, the likelihood of nurses being the focus of legal actions increases. Hartwell argues that ‘there is nothing to say that in the law this could not be transferable to nurses and other health care workers. It is only a matter of time before cases of negligence are more common amongst the other health care workers, in particular nurses.’\(^\text{398}\) However, the extent to which this therapeutic privilege extends to the rest of the health care teams has not been expressly examined either within case law or literature. Indeed, further clarification of the nurse’s role is needed in law. Whilst this paper is focused more narrowly on how therapeutic privilege relates to nurses, this endeavour is certainly made more challenging by the relative lack of literature addressing the nurse’s position both in health care teams and in law.\(^\text{399}\)

There are problems with any assumption that a defence of therapeutic privilege afforded to a doctor automatically extends to nurses purely by reason of their membership of the health care team. This can be highlighted by reflecting on the importance of professional accountability. It is well established that the standard of care expected from a nurse or doctor towards the patient is that of a reasonably skilled and experienced practitioner who has the same expertise in

that speciality, with no concessions being made for inexperience.\textsuperscript{400} Thus, health care professionals in England and Wales are judged by their peers, notwithstanding appropriate judicial scrutiny. The onus of proof for the validity of withholding information from the patient is on the doctor. In doing so it must be demonstrated that the criteria identified earlier withstands logical analysis,\textsuperscript{401} with the courts being the final arbiter of legitimacy of this decision. However, if the nurse has cared for and interacted with the patient then the likelihood is that the nurse also has withheld information. If the patient brings an action in negligence after suffering some harm, then the doctor has the opportunity to establish this standard has been met. But the absence of any clear direction from legal or professional guidance as to whether therapeutic privilege extends to the rest of the health care team, creates legal and professional ambiguity for the nurse. Nurses are not usually automatically protected in other areas if harm comes to the patient due to carrying out the doctor’s orders. Ultimately each nurse must answer for his or her own actions.\textsuperscript{402} An illustration of this might be if the doctor makes a prescribing error and the nurse administers this medication. In these circumstances, the nurse remains personally accountable - legally and professionally - for his or her actions.\textsuperscript{403}

\textsuperscript{400} M. Hartwell, ‘Can doctors and nurses still rely on the doctrine that they know best?’ \textit{Legal Medicine.} \textbf{7} (2005): 293-298 at 294. For legal authorities see \textit{Bolam v Friern Hospital Management Committee} [1957] 1 WLR 582. For consideration of liability of junior and inexperienced hospital staff in addition to a rejection of the concept of team negligence see \textit{Wilsher v Essex Area Health Authority} [1986] 3 All ER 801.

\textsuperscript{401} \textit{Bolitcho v City Hackney Health Authority} [1997] 39 BLMR para 243 as per Lord Browne-Wilkinson. Within this ruling his Lordship also states that ‘in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendants conduct, the defendant can properly be held liable for negligence’ per Lord Browne-Wilkinson at 243. He follows this with ‘I am not here considering questions of disclosure of risk’ at 243. The emphasis of this exception is relevant when considering the standard of care in relation to risk disclosure and needs to be viewed in the context of Lord Browne-Wilkinson’s entire ruling. The significance of this phrase has been considered in M.razier and J. Miola, ‘Bye-Bye Bolam: A medical litigation revolution?’ \textit{Medical Law Review.} \textbf{8} (2000): 85-114. They conclude that, ‘Either, his Lordship was simply and correctly flagging up the fact that questions of information disclosure were simply not relevant on the facts of Bolitcho, or, more probably, Lord Browne-Wilkinson considered that restraining Bolam in the context of information disclosure has already been achieved.’ para 108.


\textsuperscript{403} For an illustration of the retention of individual accountability by a doctor and a pharmacist in circumstances of a prescription error see \textit{Prendergast v Sam and Dee Ltd} [1989] 1 Med LR 36. In addition there may be shared liability when several practitioners are involved in an incident that causes harm to a patient see \textit{Dwyer and Roderick and Others} [1983] 127 SJ 805.
Nurses have direct obligations to patients in terms of their legal and professional duty of care. The importance of maintaining professional accountability is emphasised within the Nursing Midwifery Council (NMC) code of professional conduct. The NMC states that accountability is integral to professional practice. Nurses and midwives use their professional knowledge, judgement and skills to make a decision based on evidence of best practice and the person’s best interests to justify the decisions they make. The General Medical Council (GMC) states that working in teams does not change a doctor’s personal accountability for his professional conduct and the care he provides. In light of these reasons I suggest that further clarification is required in order to firmly establish whether therapeutic privilege extends to the rest of the health care team, particularly nurses.

What legal and professional options are available to nurses if they disagree with the doctor’s decision to withhold information and invoke therapeutic privilege? The nurse could engage in advocacy on behalf of the patient in situations when they feel the patient should be given this information. The preferred option would be for the doctor and nurse to discuss the issue with both giving clear reasons to support their respective positions. Hopefully, this would lead to a mutual understanding and agreement between the members of the health care team. Hewitt does not believe that the nurse has the legal right to countermand any instructions relating to the withholding information if therapeutic privilege is invoked. Similarly, Dimond warns that challenging a decision to invoke therapeutic privilege may lead to disciplinary action against the nurse. She suggests that ultimately the nurse would have to defer to the clinical decision of the doctor. This presents a dilemma for nurses. Professional codes stress the importance of team-working and communication as well as emphasising the need for effective communications with patients. The nurse, like other health personnel, has an ethical obligation to discern and act in the best interests of the patient. In the event that the nurse believes the patient’s best interests are not being served, they have a moral duty to question and challenge the doctor’s decision to withhold information. This is particularly important when the nurse has an ethical duty to the patient to inform them of the nature and extent of their illness and the options available for treatment. The nurse must balance their professional obligations with their personal ethical commitments and act in the best interests of the patient. In light of these considerations I suggest that further clarification is required in order to firmly establish whether therapeutic privilege extends to the rest of the health care team, particularly nurses.

405 Ibid.
care professionals, cannot rely on the defence, ‘I was only carrying out orders’ and would have to demonstrate that he or she acted in accordance with a responsible and logically defensible body of opinion based on acceptable practice from any qualified nurse. This, of course is the same situation for the doctor, equally they would have to justify their decision. However, the fact remains that there is no legal and professional guidance discussing therapeutic privilege in relation to the nurse and the potential issues this could create within the health care team.

5.12 Extension to areas other than risk disclosure

Could the withholding of information ever be lawfully extended to situations other than of risk disclosure? In English law, exceptions to information disclosure have usually been focused on cases which involved the non-disclosure of risks within the consent process. The justification given for withholding information from a competent patient is that there has been a reasonable assessment that this information could cause the patient serious harm. Assuming the harm of disclosure would be primarily psychological, how far could the defence of therapeutic privilege be justified in terms of withholding other information from a patient? Take the example of a diagnosis of terminal illness. Johnston and Holt argue that it would be untenable to apply therapeutic privilege to withholding diagnosis information and that it would be unlikely to be applied successfully in this jurisdiction. This is because, they argue, that informing a patient of a diagnosis is not part of the process of obtaining consent to a procedure, but rather stands alone and is fundamental to any further choices a patient may make. As I understand this view, Johnston and Holt seem to be making the point that informing a patient of a diagnosis is a necessary precursor to any gaining of consent. Thus, a ‘lack of information of the diagnosis precludes an informed choice by the patient and therefore information should never be withheld’. This view raises the issue of how far information can be separated into its component parts. Others, however, disagree that information concerning

411 Ibid.
diagnosis may in some cases cause such harm that it may be legally and ethically justified to withhold. Cote\textsuperscript{412} discusses the use of therapeutic privilege in relation to disclosure of intersexuality to children. She raises the issue that it is ‘not directly addressed in the literature or case law whether or not diagnosis (as opposed to risks of a procedure) can be withheld from a patient because it is feared that its disclosure will cause harm’.\textsuperscript{413} Dimond discusses therapeutic privilege not only in the context of risk disclosure but suggests that informing the patient that they are terminally ill may well come under this heading.\textsuperscript{414} She explains that if, in the opinion of the doctor, it would be harmful to tell a patient such disturbing news, then the doctor can withhold such information for the reason that he is acting in the patient’s best interest.

Some of these issues were highlighted in the case of \textit{Arato v Avedo}.\textsuperscript{415} Here, the case which ultimately came before the Supreme Court of California, focused on whether the law should require physicians to disclose statistics on life expectancy to their patients in cases of illness that is likely to be terminal. In this case the doctors justified their decision to withhold information regarding his statistical prognosis on disparate grounds. These included that Mr Arato had shown great anxiety about his cancer, that it was ‘medically inappropriate’ to give this specific information, that it might deprive the patient of hope, that the patient had never specifically asked for this information and that there was a level of uncertainty about the predictive value of such statistics for an individual patient. On her husband’s death Mrs Arato brought a case against the physicians arguing that the statistical information should have been disclosed. Ultimately, the Supreme Court found in favour of the physicians affirming the trial judge’s verdict. They argued that it was ‘unwise to require as a matter of law that a particular species of information be disclosed’.\textsuperscript{416} However, they emphasised that in declining to endorse the mandatory disclosure of life expectancy probabilities, they did not mean to signal a retreat from the patient - based

\textsuperscript{413} Ibid. p206.
\textsuperscript{414} B. Dimond, \textit{Legal Aspects of Nursing} (Harlow: Longman, 2004) p156.
\textsuperscript{415} \textit{Arato v Avedon} 5th Cal 4th 1172 23 Cal. Rptr 2d 131-858 P2d 598.
\textsuperscript{416} \textit{Arato v Avedon} 5th Cal 4th 1172 23 Cal. Rptr 2d 131-858 P2d 598 para 1a as per Mr Justice Arabian.
standard of disclosure’. Although this case was heard in an American jurisdiction it highlights some of the key tensions between the doctor, acting in what they perceive is in the patient’s best interests, and the level of information disclosure that is appropriate within the clinical context, particularly in relation to terminal diagnosis information.

This exploration does not represent an argument for extending therapeutic privilege into the arena of diagnosis and prognosis information, and should not be taken as such. It aims to highlight the ambiguity in this area. Given the strong ethical arguments in support of full disclosure and its particular importance in the end of life context further consideration and guidance is required on the validity of the use of therapeutic privilege to withhold diagnosis or prognosis information.

5.13 Professional guidance

The guidance produced by the GMC and the Department of Health (DH) does not refer explicitly to a doctrine of therapeutic privilege. Yet, there is an acknowledgment of situations when it would be justified to withhold information from patients. The DH acknowledges that there may be rare occasions when the health care professional believes that disclosure of information will cause the patient ‘serious harm’. In these circumstances such decisions should be discussed with the team caring for the patient and the reasons for this view documented in the patient’s records. Importantly, it is noted that, ‘in these individual cases the courts may accept such a justification but would examine it with great care’. The guidance cautions that, ‘the mere fact that the patient might become upset by hearing the information, or might refuse treatment, is not sufficient to act as a justification’.

Within ‘Consent: patients and doctors making decisions’, the GMC provides detailed guidance for doctors when making decisions in line with good medical

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417 Ibid. para 1b as per Mr Justice Arabian.
419 DH, Reference guide to consent for examination or treatment (London: DH, 2009).
420 Ibid. p13.
421 Ibid.
practice about patient care. The GMC emphasises the importance of the information exchange between doctors and patients – emphasising the need for the relationship to be based on openness, trust and good communications. Despite this, the decision in relation to how much information is shared with patients will vary, depending on the patient’s individual circumstances. The doctor should adapt their approach to discussions with patients according to: the patient’s needs, wishes and priorities; their level of knowledge about, and understanding of, their condition, prognosis and the treatment options; the nature of their condition; the complexity of the treatment; and the nature and level of risk associated with investigation or treatment. The guidance identifies the information that the doctor must give to patients. This includes information patients need, or want, in relation to: their diagnosis and prognosis; any uncertainties about either of these including options for further investigations; options for treating or managing the conditions, including the option not to treat; the purpose of any proposed investigation or treatment and what it will involved; and the potential benefits, risks and burdens, and the likelihood of success, for each option.

The GMC identifies certain justifications for withholding information from patients. Primarily, these arise when patients express the desire not to be given information about their condition or treatment. A further exception to the obligation to inform patients is described. This occurs in situations when giving the information would cause the patient ‘serious harm’. In this context ‘serious harm’ is defined as more than just the possibility of the patient becoming upset or deciding to refuse treatment.

423 Ibid.
424 Ibid.
425 Ibid.
426 Ibid.
427 Ibid.
An analysis of the guidance from the DH and the GMC raises two interrelated questions. Firstly, what is the standard of information disclosure required by the professional guidance? Secondly, is this standard consistent with that required by law? On one interpretation, it seems that the GMC requires the doctor to adhere to a standard of information disclosure consistent with the subjective particular patient standard. This is evidenced by GMC’s direction that doctors should focus on a patient’s individual situation, emphasising the importance of finding out about their individual needs and priorities. Yet the legal standard of information disclosure has traditionally been judged with reference to the medical professional standard notwithstanding the more recent acknowledgement of the prudent patient standard. Indeed, the DH recognises that ‘the standards expected of health care professionals by their regulatory bodies may at times be higher than the minimum required by law’ and that ‘where the standards required by professional bodies are rising, it is likely that the legal standards will rise accordingly’. Nonetheless, it has been recognised that the extent to which professional guidance can determine what constitutes legally valid consent is questionable. This is due in part to the standard of information disclosure being above what the law requires and a lack of obligation on the courts to follow the standards. As professional and legal benchmarks shift, they are likely to do so in an unsynchronised fashion. Should inconsistencies result, the need to minimise any variation becomes a priority. It

428 The subjective particular patient standard of information disclosure has been criticised. Mason and Brodie argue that dependence on the particular patient standard ‘opens the door to hindsight to such an extent that its use becomes unreasonable’ in K. Mason and D. Brodie, ‘Bolam, Bolam wherefore art thou Bolam? The Edinburgh Law Review. 9 (2005): 398-406 at 298-9; A. Maclean, ‘The doctrine of informed consent; does it exist and has it crossed the Atlantic?’ Legal Studies 24 (3) (2006): 386-413 comments that ‘the courts have always rejected a subjective standard’ at 394. However, despite identifying that a subjective test would be almost impossible to enforce, Jackson acknowledges that it should not be totally dismissed as an impractical moral ideal as it is valuable for the doctor to attempt to discover the individual patient’s subjective priorities by means of inquiry in E. Jackson, ‘Treatment and the impotence of tort’ Chapter 17. In S. McLean (Ed.), First Do No Harm. (Farnham: Ashgate Publishing Limited, 2006) p282. Heywood considers the position of the individual patient arguing that there, ‘must be at least some room to consider the position of the individual patient in relation to risk disclosure’ in R. Heywood, ‘Subjectivity in risk disclosure: considering the position of the particular patient’, Journal of Professional Negligence. 25 (2009): 3-14 at 4.


430 Ibid.

has been argued that the law is not well known and probably even less well understood by the medical profession. Empirical studies seem to suggest that whilst medical practitioners may be aware of such guidance regarding consent there is a lack of awareness of their substantive content. Given the evidence of this lack of knowledge, differences between legal and professional standards may result in further ambiguity.

5.14 Professional guidance and the law

A full analysis of the interplay of professional guidance and the law is beyond the scope of this paper, nevertheless, there are key issues within this dialogue it is necessary to address. These issues are relevant to a discussion of therapeutic privilege because of the importance of having a consistent starting point, transparent to the medical profession (and to patients), of the standards of information disclosure expected both professionally and legally. It is only by establishing the expected standard of information disclosure that one can start to consider any exceptions within the context of these disclosure norms. This section considers the relationship between professional guidance and the law in order to lay the groundwork for considering the professional and legal implications of therapeutic privilege. This provides further context for the argument that greater clarity is required on the validity of therapeutic privilege in English law.

There is clearly a role for the law in facilitating quality in health care. Although the place of the law in developing a framework for the doctor-patient relationship should be approached with some caution it can play a symbolic and galvanising role. Referring to this point, Lord Walker’s ruling in Chester v Afshar acknowledged the value of the iterative process between case law and

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professional guidance which might lead to the creation of a more substantive 'right' to truly informed consent for patients.\textsuperscript{436} Indeed, McLean\textsuperscript{437} recognises that doctors may be more influenced by what their professional bodies say rather than what emerges from the courts. This issue is not new, ten years ago, Brazier and Miola,\textsuperscript{438} commented on the impact of medical professional guidance on judges when evaluating information disclosure practices. They argued the influence of professional guidance was that it encouraged judges to take a more pro-patient stance emphasising the patient’s right to make informed decisions about their care.

More recently, Miola\textsuperscript{439} argued that the courts might use the guidance from the GMC in ‘Consent: patients and doctors making decisions together’ as the legal standard within information disclosure. Although this needs judicial approval, he maintained that it would not be unreasonable to expect the law to hold doctors to these standards. The conclusion being that, by using \textit{Bolam} to acknowledge professional guidelines as the gold standard that the reasonable doctor should follow, in the short term at least, patients' autonomy would be supported. The ‘hostage to fortune’ that this may produce is the law’s dependence on the continued excellence of the guidance. Maclean\textsuperscript{440} comments on the professional guidance on consent and recognises that it places greater demands on the doctor. He continues to point out that ‘if common practice develops to reflect those demands, then – by default - English law may well end up requiring the same standard of disclosure as the doctrine [of informed consent] but this standard is built on shifting sands’.\textsuperscript{441} Commenting on the relationship between

\textsuperscript{436} Chester v Afshar [2004] UKHL 41 para 58 as per Lord Walker.
\textsuperscript{440} Maclean is referring to GMC, Seeking patients consent: the ethical considerations (London: General Medical Council, 1998) but the point stands for the GMC, ‘Consent: Patients and doctors making decisions together’ (London: GMC, 2008) in A. Maclean, ‘The doctrine of informed consent; does it exist and has it crossed the Atlantic?’ \textit{Legal Studies.} 24 (3) (2006): 386-413 at 411-413.
\textsuperscript{441} A. Maclean, ‘The doctrine of informed consent; does it exist and has it crossed the Atlantic?’ \textit{Legal Studies.} 24 (3) (2006): 386-413 at 412.
professional guidance and the law Miola\textsuperscript{442} concludes that as the law moves closer to a prudent patient test and greater respect for patient autonomy it is important that this relationship does not stand still. He accepts that comprehensive and authoritative guidance from the professional sector is more demanding than the law and, as such, it can represent a gold standard to the minimum provided by the law. This is emphasised by the concerns expressed that the 2008 GMC guidance\textsuperscript{443} represented a shift of the professional ethical standard of information disclosure within consent downwards towards the legal standard rather than the legal standard moving upwards towards the professional ethical standard.\textsuperscript{444}

Accepting that the law, professional guidance and the medical profession seem to operate in some sort of triad of influence, it would seem prudent to ensure a level of consistency and dialogue between each. The interesting issue here, it seems, is the level of influence each of these parties has on the others. Establishing a coherence and consistency in the message given by each is vital - particularly in regards to issues of communication. This is because, by its very essence, communication involves a fourth, and arguably the most important, member of this company: the patient. Thus, analysing the relationship between these parties and the standards they provide in terms of information disclosure has profound implications for the patient and the level of communication they can expect. This potential gap between professional guidance and standards expected in law leaves a vacuum and thus a lack of clarity which needs to be addressed.

\textsuperscript{443} GMC, \textit{Consent: Patients and doctors making decisions together} (London: GMC, 2008)
\textsuperscript{444} S. Forvargue and J. Miola, ‘How much information is ‘enough’? ’ \textit{Clinical Ethics} 5 (13) (2010): 13-15. Forvargue and Miola discuss the relationship between the guidance in GMC, \textit{Consent: Patients and doctors making decisions together} (London: GMC, 2008) and the law pertaining to the legal standard of information disclosure. They conclude that if the law requires doctors to act ‘reasonably’ in terms of information disclosure then the GMC guidance may be seen by a court as the definition of how the reasonable doctor would act. In this respect, the law would essentially be drafted by the medical profession at 15.
5.15 Ethical justifications for disclosure of information

There are strong ethical justifications to support disclosure of information with patients. Any exception to this by withholding information that would usually be disclosed to patients needs to be weighed against these potential objections. Obligations of truth-telling are usually justified on the basis of the principle of respect for autonomy, obligations of fidelity, and the relationship of trust that is inherent in the doctor–patient relationship.\(^{445}\) Health care professionals are generally respected for their honesty\(^ {446}\) and this covenant of trust between doctor and patient is central to the practice of medicine.\(^ {447}\) A lack of candour or outright deception, however well intentioned, can undermine the public’s confidence in the medical profession.\(^ {448}\)

It has been argued that at the heart of truth-telling is the notion of autonomy.\(^ {449}\) The decision not to tell the truth to a patient, whether about diagnosis, prognosis or the potential risks or benefits of the alternative treatment options has been described as the doctor is making a unilateral decision to deny the patient the opportunity to exercise their autonomy.\(^ {450}\) Respecting the autonomy of patients has become a central ideal in modern-day health care. The guiding principle of individual autonomy is the belief that patients should have a meaningful role in decisions about their own care and treatment. In this sense, autonomy relates to having an authentic role in decision-making. In a wider context, the opportunity and ability to exercise choice allows individuals to have control over their own destiny. As such, autonomy is seen as something to aspire to and strive towards, the idea being to maximise autonomous decision-making as far as

\(^{445}\) J. Wong, Y. Poon, E. Hui, ‘Can I put the medicine in his soup, Doctor?’ *Journal of Medical Ethics*. 31 (2005): 262-265


possible. Autonomy, on this view, acknowledges that rather than decisions having to be fully autonomous they need to be as autonomous as practicable. As autonomy is about making decisions, arguably, part of this process requires that we have the relevant information on which to base that decision. There is evidence to suggest that many patients want detailed diagnostic and prognostic information. In addition to this, far from increasing anxiety and distress, communicating information effectively has been said to reduce patients’ anxiety levels. The corollary of this is that a lack of information has been linked with higher levels of worry in patients.

Further risks of non-disclosure of information include the possibility that patients who remain uninformed about their condition may fail to seek medical attention and treatment when they should. Patients may make decisions affecting their lives that they would not have done had they been in possession of this information. This can result in a patients being prevented from making informed decisions about their care. In addition, withholding relevant information without patients’ knowledge or consent may have negative long-terms consequences for the medical profession particularly in terms of undermining the trust and confidence patients may place in the doctor. Indeed, examinations of healthcare professionals’ perspectives regarding information disclosure in clinical practice appears to identify a presumption in favour of disclosure and an uncertainty as to the precise nature and applicability of therapeutic privilege.

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455 R. Heywood, A. Macaskill, K. Williams, ‘Informed consent in hospital practice: health professionals’ perspectives and legal reflection’, Medical Law Review. 18 (2010): 152-184 at 160. However, it is acknowledged that there is uncertainty as to the extent to which the practitioners studied recognised any withholding of information as therapeutic privilege, but rather using professional judgment in tailoring information to the needs of individual patients.
5.16 A way forward

Whilst there are strong ethical justifications to support information disclosure, there remains the possibility of individual circumstances when disclosure could cause serious harm to patients. One way to reconcile this with the ethical arguments in favour of disclosure is to ensure that this privilege is clearly articulated and the limits of its application explicitly considered. This could be done in several ways. Further articulation in law could be obtained by the judiciary considering the areas of ambiguity identified. This could be achieved within comments on legal judgements, obiter or not. One possible objection to this might result from an unwillingness to bind the judiciary and the medical profession to a course of action in future, unforeseen circumstances. This is a reasonable concern. However, providing further clarification on the status of therapeutic privilege in English law and establishing its boundaries is timely given the emphasis on disclosure of information and its importance for patients.456 Another avenue of providing further clarification could be developing a joint statement employing expertise from legal and professional arenas. A constructive dialogue with professional groups, legal representatives and patient groups to discuss the existence of such a privilege in contemporary health care would seem a positive first step. Within this discourse an exploration of the ethical justifications for and against such a notion, along with its consistency with principles in modern health care is needed. This is just the area that 'The American Medical Association Council' has attempted to address in their report on ethical and judicial affairs on withholding information from patients. Here, the validity of therapeutic privilege was explicitly considered with the clear recommendation that withholding information from patients without their knowledge or consent is ethically unacceptable.457 A similar exposition of

456 The abolition of therapeutic privilege in relation to informed consent is discussed in J. Berg, P. Appelbaum, C. Lidz, L. Parker, Informed Consent: Legal theory and clinical practice (Oxford: Oxford University Press 2001). Here, it is concluded that, 'if there is any room at all for therapeutic privilege, it must be framed narrowly in terms of interference with patients decision-making capabilities and applied only in extreme cases' p85.
457 N. Bostick, R. Sade, J. McMahon, R. Benjamin, 'Report of the American Medical Association Council on Ethical and Judicial Affairs (CEJA): withholding information from patients: rethinking the propriety of ‘therapeutic privilege’ Journal of Clinical Ethics. 17 (4) (2006): 302-306. Although there is recognition within the recommendations that there might be circumstances when a delayed disclosure could be considered. For further comment on this report see D. Pirakittikular,
therapeutic privilege within the English context would be useful in order to establish the ethical, professional and legal position. Within this it is also necessary to develop clear guidance on whether this concept extends to areas other than risk disclosure - such as diagnosis, prognosis, and the extent to which therapeutic privilege extends to other professionals in the health care team. In order to frame this discussion in clinical practice scenarios could be used to illustrate and explore the potential tensions within information disclosure and test the validity of therapeutic privilege.458

5.17 Conclusion

Providing patients with information is seen as a fundamental part of respecting their autonomy. The law reflects this principle through the concept of consent and the importance it places on respect for patient autonomy. Despite this, there is an acknowledgement within case law that there may be circumstances when the doctor may withhold information to prevent serious harm to the patient. This has been discussed primarily in relation to disclosure of risks. The exception has been viewed as part of the legal benchmark based on the professional standard of information disclosure. As the standard of information disclosure moves towards one based on the reasonable prudent patient standard, the need for a formal articulation of a doctrine of therapeutic privilege intensifies. In this context, doctors require the privilege to withhold information, which would usually be disclosed, on the grounds of preventing serious harm to their patients. However, there are strong ethical arguments in favour of disclosure of information to patients. In light of these, further clarification is required on the grounds on which this exception exists, the information that could lawfully be withheld and how this exception extends to rest of the health care team, particularly nurses.


458 For examples of scenarios which illustrate additional information disclosure dilemmas and exploration of how to practically apply the American Medical Association guidelines see N. Sirotin and B. Lo, ‘The end of therapeutic privilege?’ Journal of Clinical Ethics. 17 (4) (2006): 312-316.
5.18 The law in flux

Before moving onto Chapter Six, I would first like to address the issues raised by a legal case which was brought before the Court of Session in the Scottish Courts in 2013, after the previous paper was published. The case of N M v Lamarkshire Health Board\(^{459}\) illustrates the fluidity of the legal position in relation to the legal standard of information disclosure. In brief, this case involved a pregnant diabetic woman pursuing recompense on behalf of her son in respect of the grave injury that he sustained at the time of his birth. In part, the judgement involved a consideration of consent and information disclosure. It was argued that the pursuer, given her medical history, ought to have been given specific advice about the risks associated with a vaginal birth and so should have been counselled about the option of a delivery by caesarean section. The grounds for this particular element of the case lies in the contention that there was a duty on the obstetrician, voluntarily and in the absence of any inquiry to advise a diabetic mother of the risks of shoulder dystocia. The legal question under consideration involved how the legal standard of information disclosure should be measured. In doing this, the Court considered the impact of the judgement in Pearson\(^{460}\) that has arguably been taken to introduce a standard of information disclosure into English law based upon what the ‘reasonable’ patient would wish to know. Here, referring to Pearson, the Court asserted,

‘while it may be taken that wholly in isolation the passage might be suggestive of a “reasonable patient” approach, contrary to the approach of the majority in Sidaway, we are persuaded that when the judgement is read as a whole it is evident that the Court of Appeal was not departing from the majority view in Sidaway that the test for liability for failure to warn of risks was essentially the Bolam test’.\(^{461}\)

This reveals a denial of a move towards a legal standard of information disclosure based upon a ‘reasonable’ patient standard and a retreat towards a

\(^{459}\) N M v Lanarkshire Health Board [2013] CSIH 3.

\(^{460}\) Pearson and another v United Bristol Health Care NHS Trust [1998] 47 BMLR 118 para 124 as per Lord Woolf.

\(^{461}\) N M v Lanarkshire Health Board [2013] CSIH 3 para 24 as per Lord Eassie.
professional standard of disclosure. This thesis has argued that as a result of a move towards a standard of information disclosure based upon what the reasonable patient would wish to know, rather than one based upon the professional standard, there is a requirement for a discrete doctrine of therapeutic privilege. This is because if the standard of information disclosure is judged by reference to the patient and not the doctor, then the doctor requires a mechanism to legally withhold information in particular circumstances. Nonetheless, given the strong ethical justifications for disclosure of information I have argued that this privilege needs to be reviewed in terms of its scope. However, if the standard of information disclosure remains based upon the clinical judgement of the professional then the need for a privilege diminishes as it is in the professional’s remit to decide on the level of disclosure within established legal norms.

The wider implications of this distancing from a ‘reasonable’ patient standard of information disclosure suggest that the reflection of a greater respect for patient autonomy and patient rights within recent case law might be uncertain. However, at present this case involves the Scottish jurisdiction and has yet to be heard at the United Kingdom (UK) Supreme Court. That being said, this case illuminates the significance of interpretation of previous case law and the level of uncertainty on how the legal standard of disclosure is measured. This not only has the potential to affect patients and doctors already involved in legal disputes regarding information disclosure but also provides further lack of clarity for how disclosure practices carried out in the clinical setting would be judged legally.

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462 For example Chester v Afshar [2004] UKHL 41.
Chapter Six
The duty of candour in disclosing medical errors: the ethical foundations and legal opportunities

6.1 Abstract

There are strong ethical justifications for disclosing medical errors to patients. Primarily, these justifications are based upon respect for patient autonomy. This paper presents an exposition of the ethical and practical considerations which underpin disclosure of medical errors to patient. This analysis provides the foundation for an examination of how the law can best support a duty of candour.

6.2 Key words

Duty of candour; information disclosure; medical errors; patient autonomy

6.3 Introduction

The importance of providing patients with information in relation to their health care has been established as central to providing care that meets legal, ethical and professional requirements. In many countries, patient safety is now a key issue in health care quality and risk management. A commitment to openness with patients after a medical error has occurred has been recognised within key guidelines and by the NHS Constitution. Despite these laudable assurances

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463 National Audit Office, A safer place for patients: learning to improve patient safety (London: National Audit Office, 2005): 1. In England, the National Health Service (NHS) defines patient safety incidents as, ‘any unintended or unexpected incidents which could have, or did, lead to harm for one or more patients receiving NHS-funded care’ National Patient Safety Agency (NPSA) Medical Error. (2010) Issue 2 p8. This paper does not extend to instances of ‘purposeful reckless actions that are intended to directly or indirectly harm the patient’ B. Liang, ‘The adverse event of unaddressed medical error: identifying and filling holes in the health care and legal systems’, Journal of Law, Medicine and Ethics. 29 (2001): 346-368 at 346.

464 NPSA, ‘Being open’ (NPSA, 2009). This guidance defines ‘being open’ as, ‘acknowledging, apologising and explaining when things go wrong; conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent
several high profile inquiries into poor standards of health care at specific institutions have revealed incidences of denial, substandard care and a failure to acknowledge mistakes.\textsuperscript{466} This paper will examine how ethical considerations support the need for a legal duty of candour. Candour in the context of disclosure after a medical error is defined as, ‘ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or question asked about it’.\textsuperscript{467} In practice this means that in the event of medical error occurring there is a duty of candour which necessitates that the patient be informed. In order to support this argument I will first establish the strong ethical justifications, premised on autonomy, which underpin such a duty.

\subsection*{6.4 Patient autonomy and obligations of candour}

There are strong ethical reasons for disclosing medical errors to patients. These justifications focus primarily on the principle of respect for individual autonomy. Whilst full autonomy has been viewed as an ideal, aiming for decision-making which is substantially autonomous is important\textsuperscript{468} with the intention of maximizing the autonomy of individuals as far as possible. It is acknowledged that understanding and freedom from constraint are a matter of degree. Harris’s conceptualisation of autonomous decision-making, for example, requires the individual to base their decisions on valid, relevant information; to be able to

\begin{footnote}{DH, \textit{NHS Constitution} (London: DH, 2013). The constitution includes a pledge to acknowledge mistakes when they happen, to apologise, explain what went wrong and put things right quickly and effectively. There is also an expectation that NHS staff should be open and honest with patients if things go wrong or mistakes happen.}\end{footnote}


\begin{footnote}{R. Francis, \textit{The Mid-Staffordshire NHS Foundation Trust Public Inquiry. Final report} (2013) available at \url{http://www.midstaffspublicinquiry.com/}; (accessed 20th June 2013) p7.}\end{footnote}

\begin{footnote}{T. Beauchamp and J. Childress, \textit{Principles of Biomedical Ethics} (Oxford: Oxford University Press, 2009) p102.}\end{footnote}
reason correctly; and be in control of their desires and actions. Information is required in order to be able to assess the options available and make a choice as to which are appropriate to the patient given their values, beliefs and needs. If an individual does not have possession of all the information they require, then autonomous decision-making cannot occur. Indeed, the central role of respect for autonomy is demonstrated by the well-established legal and ethical practice of gaining informed consent before any health care intervention. It is important to recognise that information provision is also important post-intervention. This is because decisions will need to be taken by the patient about future healthcare, seeking further treatment, or pursuing legal or professional remedies. In these circumstances, respect for patient autonomy involves an obligation to inform patients of information, which they need to decide on a course of action following a medical error in terms of their future health care needs or their right to seek legal redress. As such, respect for patient autonomy, in this context, comprises not only of the obligation to disclose information before treatment but also extends to post-hoc explanations of adverse outcomes.

6.5 Paternalism

There is empirical evidence that patients are not always informed when a medical error has occurred. A possible reason for this non-disclosure is that it is in the patient’s best interests that this information is withheld. Taking this decision about whether or not to impart this information, is clearly a paternalistic move. Restricting information available to the patient on the grounds that it is in

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their best interests is an example of ‘hard paternalism’.\textsuperscript{472} There are those who argue that, given certain circumstances, ‘hard paternalism’ can be justified.\textsuperscript{473} However, these justifications are not applicable in the case of disclosing medical errors to patients. This is because non-disclosure risks exposing the patient to further harm in that it could deny the patient the opportunity to seek treatment to remedy the error, together with preventing the prospect of pursuing appropriate recompense for such harm. In these cases being informed about whether a medical error has occurred is vital in terms of the patient making informed decisions about their health care treatment, whether or not to seek further treatment, as well as evaluating the risks and benefits of such interventions. Similarly, it is argued that a degree of mild paternalism can be justified if it can reasonably be expected to promote the primary goods that all reasonable individuals want to possess, or prevent individuals from taking steps that would interfere with realising their own conception of the good.\textsuperscript{474} In relation to disclosure of medical errors these claims are not relevant in providing justification to support non-disclosure. This is because withholding information could not be described as ‘mild’ paternalism as it involves deliberate misrepresentation or non-disclosure of the facts. As such, this could impact on the patient’s future health care decisions as they do not possess the relevant information they require in order to make informed choices.

Moreover, in the case of disclosure of medical errors there is clear empirical evidence that patients wish to be informed if a medical error occurs.\textsuperscript{475} Within this dialogue patients want: information that an error has occurred and an

\textsuperscript{473} Ibid. p186. Hard paternalism can be justified if the following circumstances can be met: ‘a patient is at risk of significant, preventable harm; the paternalistic action will probably prevent the harm; the projected benefits to the patient of the paternalistic action outweigh its risks to the patient; there is no reasonable alternative to the limitation of autonomy; the least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted’\textsuperscript{474} N. Levy, ‘Forced to be free? Increasing patient autonomy by constraining it’, \textit{Journal of Medical Ethics}. 10\textsuperscript{th} February 2012 10.1136/medethics2011-100207 [Epub ahead of print].
\textsuperscript{475} T. Gallagher, W. Levinson, ‘Disclosing harmful medical errors to patients’, \textit{Archives Internal Medicine}. 165 (2005): 1819-1824 at 1822. This wish to know is reflected in literature reviews on communication with patients after medical error showing that patients and families strongly support disclosure. For example, in K. Mazor, S. Simon, J. Gurwitz, ‘Communicating with patients about medical errors’, \textit{Archives Internal Medicine}. 164 (2004): 1690-1697.
explanation of why it happened; information on how it will be prevented from happening again; and an apology. Whilst, of course, this may not be the case for all patients in all circumstances, given the ethical justifications for disclosure it seems prudent to take the approach that disclosure should be the norm unless the patient says otherwise. For these reasons patients’ autonomy interests are not served by withholding information on the grounds that it is thought that this would be what the patient may benefit from and want.

Despite this, there are claims that paternalism can be justified as autonomy can be too easily undermined by illness and that patients have difficulty being able to understand or recall information they are given about their health. Yet, health care professionals should possess the ability to communicate sufficiently well in order to translate relevant information into language and concepts which can be understood. This is not only ethically desirable in terms of promoting a patient’s autonomy but is also a professional requirement.

It is important to recognise that information provision between the doctor and patient exists within a wider context of the practical considerations of providing health care with its competing demands, perceptions and loyalties. Here, issues of trust and the perception of medicine provide an important context from which to consider disclosure practices. It is these more applied concerns in relation to the disclosure of medical errors which will now be focused upon.

478 For a more in depth discussion addressing the unrealistic view that doctors are able to determine what will benefit their patients see R. Veatch, ‘Doctor knows best: why in the new century physicians must stop trying to benefit their patients’, Journal of Medicine and Philosophy. 25 (6) (2000): 701-721.
6.6 The context of information disclosure

A further ethical justification to support disclosing medical errors to patients is that it will help enhance trust between patients and health care professionals and institutions. This relationship of trust is integral in the doctor–patient relationship. There is a risk that if information is withheld, and the patient or family discover this at a later date, the consequences could be a loss of trust resulting in damage to the doctor-patient relationship. Despite concerns that disclosing medical errors may affect patients' confidence in healthcare professionals, it may be that the process of admitting a mistake and asking forgiveness could actually strengthen the doctor-patient relationship. Indeed, medical error disclosure programmes with an offer of compensation for harmful medical errors have been implemented without an increase in total claims and liability costs. Yet, the evidence of the medical and legal consequences of disclosure is seen as an open question for the foreseeable future. In any case, the process of disclosure may help the doctor cope with the harmful effects of making a mistake. Furthermore, an absence of information can adversely

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482 J. Wong, Y. Poon, E. Hui, 'Can I put medicine in his soup doctor?' Journal of Medical Ethics. 31 (2005): 262-265; P. Benn, 'Medicine, lies and deception', Journal of Medical Ethics. 27 (2005): 130-134.
484 A. Kachalia, S.R. Kaufman, R. Boothman, S. Anderson, K. Welch, S. Saint, M. Rogers, 'Liability claims and costs before and after implementation of a medical error disclosure program', Annals of Internal Medicine. 153 (4) (2010): 213-221. The study did acknowledge limitations that malpractice claims generally declined in the geographical area during the latter part of the study and that the findings might not apply to other health systems.
affect patients and their attempts to cope with medical errors which in turn can lead to additional trauma.\textsuperscript{487}

Additionally, there may be concerns about damaging other colleagues’ careers or reputations if patients are informed about a medical error. Equally though, any lack of disclosure and potential ‘cover-up’ not only damages reputations but also has profound implications for levels of trust in health care professionals and on perceptions held by society as a whole. Preserving personal and institutional reputations at the expense of providing patients with information when a medical error has occurred allows potentially unsafe practice, putting others at risk of harm, to continue. This is critical in restoring the public’s trust in the honesty and integrity of the health care system.\textsuperscript{488} Although, it has been cautioned that the perception of medical practice is based upon an ‘ideal of error-free practice’.\textsuperscript{489} As such, the vast number of medical errors which occur make it impractical for each of them to be disclosed and would only lead to an enormous amount of mistrust.\textsuperscript{490} These concerns relate not only to the disclosure process but also go to the heart of public perception on the abilities and limits of medical practice. Fundamentally though, disclosing and openly discussing medical errors provides an opportunity for lessons to be learnt and clinical practice to be developed in terms of individual practice and in terms of the wider health care system.

\section{6.7 The disclosure gap}

Notwithstanding these ethical arguments several empirical studies support the view that disclosing information to patients after a medical error remains problematic. Gallagher \textit{et al}\textsuperscript{491} found that whilst many physicians strive to be truthful there remains a reluctance to provide patients with even basic

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information when an error occurred. Similarly, O’Connor et al found that physicians commonly give only a partial disclosure in relation to adverse events. Research also reveals that patients are sensitive to attempts to mislead them through careful word choice and did not condone healthcare professionals ‘muddling through the issue elegantly’. Indeed, the nature of the communication process relating to the disclosure of medical errors shows a wide variation in the type of words used by physicians to disclose medical errors and a series of ‘facilitating and impeding factors’ which affect the doctor’s willingness to disclose. Significantly, a report by the National Audit Office in 2005, revealed that only 24% of NHS trusts routinely inform patients of a patient safety incident and 6% admitted to never informing patients. This gap between patients’ desire to be given information and its actual disclosure after medical error supports the need for a duty of candour to be established in law.

So far, I have argued that respect for patient autonomy provides the fundamental justification for disclosing medical errors to patients. In making this argument I

495 T. Gallagher, J. Garbutt, A. Waterman, D. Flum, E. Larson, B. Waterman, W. Claiborne Dunagan, V. Fraser, ‘Choosing your words carefully’, *Archives Internal Medicine*. 166 (2006): 1585-1593. For example, in this study 33% of respondents stated they would explicitly apologise for the error whilst 61% state they would simply express regret.
contend that paternalistic reasons do not provide sufficient grounds for withholding information from patients in this context. These claims provide support for establishing a duty of candour from an ethical perspective. In the following sections I will move this line of argument into the legal sphere and consider how a duty of candour has been considered in law to date and the opportunities and challenges that framing such a duty in law might present.

6.8 Duty of candour: legal context

Whilst the concept of a general duty of candour has been briefly considered in cases which pertain to requests for access to records\(^{499}\) in order to pursue legal proceedings, there has been little consideration of whether such a duty exists in relation to disclosure of medical errors to patients. In *Naylor v Preston Area Health Authority*\(^{500}\) Lord Donaldson ‘argued for a duty of candour resting on the professional man’.\(^{501}\) His comments, which he referred to as ‘admittedly and regretfully obiter’,\(^{502}\) identified the duty of candid disclosure as ‘….one aspect of the general duty of care arising from the patient-medical practitioner relationship or the patient’s relationship with the hospital authority and which gave rise to rights both in contract and in tort’.\(^{503}\)

The most recent and significant case concerned *Powell v Boladz*.\(^{504}\) An action was initiated by Mr and Mrs Powell due to the failure of health care staff to diagnose and treat Addison’s disease in their son, ten-year-old Robert, who

\(^{499}\) *Naylor v. Preston Area Health Authority and other appeals* [1987] 2 All ER 353; *Lee v. Southwest Thames Regional Health Authority* [1985] 2 All ER 385.

\(^{500}\) *Naylor v. Preston Area Health Authority and other appeals* [1987] 2 All ER 353.

\(^{501}\) Ibid. para. 360 as per Lord Donaldson.

\(^{502}\) Ibid.

\(^{503}\) Ibid. The duty of disclosure after medical error was addressed previously in *Lee v. Southwest Thames Regional Health Authority* [1985] 2 All ER 385 para 390 as per Lord Donaldson. Here, Lord Donaldson, in obiter dicta asked that some thought be given to the nature of the duty of disclosure owed by the doctor and a hospital post treatment.

\(^{504}\) *Powell and another v. Boldaz and others* [1997] 39 BMLR 35. The circumstances of the case found that a catalogue of errors had occurred in Robert’s care. These included presentations to the GP with an incorrect diagnosis being given and a failure to obtain a test for Addison’s disease despite the need for testing being recorded in the notes. Although Robert’s condition worsened a hospital admission was rejected by an attending GP. Following repeated concern from Robert’s family the GP eventually agreed to write a letter of referral but refused to order an ambulance. A few hours after his parents drove him to the hospital Robert suffered a cardiac arrest and died. In summary, it was agreed that the disease was not diagnosed, yet if it had been, Robert could have been treated and the treatment would probably have been successful.
subsequently died. The alleged misinformation which followed these events, was said to have caused further psychiatric damage to the claimants. Robert’s parents sought to establish that the defendants owed them a duty of care which required the defendants to be honest about events which led to their son’s death. They contended that a ‘cover-up’ in terms of removing and substituting documents after Robert’s death was performed. This failure to be candid in the first instance and subsequent alleged ‘cover-up’, they argued, ran contrary to a duty of candour to which they were entitled.\(^505\) In the Court of Appeal, Lord Justice Stuart-Smith, ruled,

‘… a doctor must give careful, truthful and candid information to his patient for the purpose of his treatment or, if need be, to advise him that no treatment is required. Failure to do so, resulting in injury, will expose the doctor to liability in negligence. But these dicta afford no authority for the proposition that there is some kind of free-standing duty of candour, irrespective of whether the doctor-patient relationship existing in a healing, or treating context, breach of which sounds in damages, such damages involving personal injury. This would involve a startling expansion of the law of tort.\(^506\)

This expansion was seen as untenable by Lord Justice Stuart Smith because it would mean that duties and obligations of disclosure by the doctor would exist to the patient’s relatives, outside of the duty of care in the doctor-patient relationship. Lord Justice Stuart Smith did not consider that, ‘a doctor who has been treating a patient who has died, who tells relatives what has happened, thereby undertakes a doctor-patient relationship towards the relatives.’\(^507\) Third parties, as the Powells were viewed in this case, were thought not to be sufficiently proximate as to give rise to a duty of care by the doctor.

\(^{505}\) *Powell and another v. Boldaz and others* [1997] 39 BMLR 35 para 39 and 46 as per Lord Justice Stuart-Smith.
\(^{506}\) *Ibid.* para. 46 as per Lord Justice Stuart-Smith. He also identifies that ‘there are many situations where a doctor will have close contact with another person, without the relationship of doctor-patient arising so as to involve the duty of care’ para 45 as per Lord Justice Stuart-Smith.
\(^{507}\) *Ibid.* para 46 as per Lord Justice Stuart-Smith.
The European Court of Human Rights (ECHR) heard argument from the Powells that there was an obligation incumbent on the state not only to investigate the death of a child but also to provide an accurate and truthful account to the parents about the circumstances in which the child died. The applicants submitted that these guarantees derive from Articles 2 (the right to life), 8 (the respect for private and family life) and 10 (the right to freedom of expression and information) of the Convention. Without undertaking a detailed examination of the merits of the claims, the Court ruled that, having withdrawn previous appeals to the Welsh Office investigating the integrity of the records and by settling their civil action, the Powells could no longer claim to be ‘victims’ within the meaning of ECHR law. For that reason, the complaints were declared inadmissible. In so doing, the Court missed an important opportunity to clarify whether European human rights law comprises a positive obligation of a duty of candour, and, if it did, the circumstances in which it might be upheld.

There is clearly a reluctance to endorse a duty of candour in common law and European human rights law. Yet, it has been recognised that the ‘law of tort expands and contracts all the time’ and that European Convention is a ‘living instrument’ whose provisions must be interpreted in the light of prevailing conditions. As such it does not seem unreasonable to expect that the law should be able to encompass and reflect changes in duties and obligations within contemporary health care. Although incremental expansion of the law to develop a common law duty of candour has been explored, given the previous lack of judicial enthusiasm to incorporate such a duty, combined with a lack of a consistent approach in common law decisions, it seems unlikely that a common law solution might be developed. Given the strong autonomy-based justifications for disclosure of medical errors it is important to evaluate the legal avenues of imposing a legal duty of candour. The following sections seek to analyse the current legal position together with providing an evaluation of the legal options in terms of their level of consistency with this ethical grounding.

6.9 The framing of a legal duty

There are clear ethical reasons in support of the principle of being open with patients and disclosing information if a medical error has occurred. Given the strength of these justifications and the absence of a duty of candour in common law the issue remains in a legal vacuum.\textsuperscript{511} Two possible options have been considered as a workable solution to this problem: a contractual obligation built into standard NHS health care commissioning contracts and a statutory legal duty of candour.

6.10 Contractual duty of candour

The Government consulted on imposing a duty of candour as a contractual requirement\textsuperscript{512} to be inserted into standard NHS contracts between NHS commissioners of services and NHS funded providers, such as NHS acute, ambulance, community and mental health providers. This contractual duty of candour was implemented in the NHS Standard contract in 2013/14.\textsuperscript{513} It does not, however, affect primary care providers, or private health care providers. The contractual duty of candour requires an annual declaration of the commitment to openness to be published by health care organisations which includes an undertaking to always tell patients if something has gone wrong during their care. Censure for breaking this promise could result in financial consequences and remedial action.\textsuperscript{514} Ultimately serious or persistent breaches could lead to a suspension and/or termination of a provider’s contract.\textsuperscript{515}

\textsuperscript{511} V. Shekar, M. Singh, K. Shekar, P. Brennan ‘Clinical negligence and duty of candour’, \textit{British Journal of Maxillofacial Surgery}. 29 (2011): 593-596 state that, ‘Medical professionals recognise the need for open disclosure of medical errors that occur during treatment and endorse it as an ethical obligation to do so. However, there is no legal duty to disclose to a patient an adverse event that might have occurred during their treatment’ at 594.

\textsuperscript{512} DH, \textit{Implementing a ‘duty of candour’; a new contractual requirement on providers}. (London: DH, 2011).


\textsuperscript{514} DH, \textit{Implementing a ‘duty of candour’; a new contractual requirement on providers}. (London: DH, 2011).

However, there were mixed responses to the consultation which reveal divided opinion about whether a contractual mechanism is the best option for requiring openness in the NHS.\(^{516}\) The main reason respondents disagreed with the contractual requirement was that they felt it was too onerous to implement, with some respondents arguing for statutory duty.\(^{517}\) Indeed, the final recommendations from the Mid-Staffordshire Inquiry clearly endorsed the need for a statutory duty.\(^{518}\) The contractual arrangement, although deemed to be a step in the right direction, was judged to be insufficient.\(^{519}\) There remain two key problems with any attempt to inscribe an obligation of candour within NHS contractual arrangements. Firstly, the contractual arrangements set out by the Government currently only apply to those organisations holding standard NHS contracts.\(^{520}\) As there are areas of health care provision not included within standard NHS contracts this introduces inconsistencies in the regulation for clinicians and for patients. Secondly, the contractual duty would only apply to incidents already reported through existing national systems of error reporting which would result in a failure to prevent ‘cover-ups’.\(^{521}\)

The extent to which pursuing a contractual duty of candour is congruent with respect for patient autonomy as the ethical justification for a legal duty of candour is also suspect. This is because the contractual duty exists between NHS commissioning boards and NHS health care providers. Those who provide care to the patient, the individual health care professionals, are not directly included within this contractual duty. Moreover, the fact that this duty exists outside of the health care professional-patient relationship means that patients are located outside such a duty and therefore patient rights are not centrally


\(^{517}\) Ibid. p8. 48.4% of respondents to the consultation did not think the contractual mechanism would be effective. Of those 49.2% felt it would be too onerous to implement whilst 22% argued that a statutory duty was required.


\(^{521}\) See speech from Baroness Masham 13th February 2012 Colum 573 available at [http://www.publications.parliament.uk/pa/ld201213/ldhansrd/text/120213-0002.htm] [accessed 23rd May 2013].
located within this legal obligation. A contractual duty of candour within standard NHS contracts also means that those who provide care outside these contracts would not be subject to the duty of candour.\textsuperscript{522} If a duty of candour is founded upon respect for patient autonomy it is inconsistent for only those patients who receive care from NHS providers to benefit from such a duty. This lack of coherence in providing such a contractual duty suggests that this route for providing a duty of candour lacks compatibility with a universal respect for patient autonomy.

6.11 Statutory duty of candour

Over the last decade several recommendations have been made to introduce a statutory duty of candour\textsuperscript{523}, each of which has been rejected. The Government now plans to introduce a statutory duty of candour\textsuperscript{524} (in addition to the contractual duty of candour) as a direct response to the Mid-Staffordshire recommendations,\textsuperscript{525} although this has yet to be debated or voted upon in either Houses of Parliament. It is important to consider how this statutory duty will be framed\textsuperscript{526} and how this differs from other recommended configurations. Within the suggestions made by the Mid-Staffordshire Report a statutory duty of

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\begin{enumerate}
\item For example, it is acknowledged that this contractual obligation could not ‘automatically be applied to GPs, Dentists, providers of primary ophthalmic services and Pharmacists’ DH ‘Implementing a ‘duty of candour’; a new contractual requirement on providers.’ (London: DH, 2011) p12. This was an omission which the vast majority of responders in the consultation process disagreed with see DH, ‘Implementing a ‘duty of candour’; a new contractual requirement on providers.’ Analysis of consultation responses. (London: DH, 2012) p14.
\item Lord Donaldson, Making Amends: a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS (London: DH, 2003) 1-128 at 18; House of Commons Health Committee ‘Patient Safety Sixth Report of Session 2008-9’ Vol 1 (2009) paragraph 90-1; In February 2012, the House of Lords considered an amendment to the Health and Social Care Bill that would have introduced a statutory duty of candour for all registered health care providers by modifying the Care Quality Commission’s (CQC) registration regulations to include such a duty. This amendment was defeated in the House of Lords by 234 votes to 198.
\item It is acknowledged in the Government response that ‘we will need to carefully consider the scope of this duty on all providers’ p46 in DH, Patients first and foremost. The initial Government response to the Report of the Mid-Staffordshire NHS Foundation Trust Public inquiry (2013) available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf [accessed 20th August 2013].
\end{enumerate}
\end{footnotesize}
candour should be imposed upon not only health care providers, but also on registered medical practitioners, registered nurses and other registered professionals.\textsuperscript{527} It is also recommended that criminal sanctions should exist in circumstances when anyone who owes a duty of candour knowingly obstructs the performance of these statutory duties, provides misleading information to a patient or nearest relative, or is dishonest in the information provided to commissioning or regulatory bodies.\textsuperscript{528}

6.12 The scope of a statutory duty of candour

The proposed statutory duty outlined by the Government plans to ‘reinforce the existing contractual duty’.\textsuperscript{529} In doing so the Government’s proposed statutory duty intends to obligate ‘health and care providers to inform people if they believe treatment or care has caused death or serious injury, and to provide an explanation’.\textsuperscript{530} However, there is no further discussion on precisely how formation of this statutory duty will reinforce the existing contractual duty. As a result there are important legal questions arising from addressing a duty of candour in both contractual and statute law. For example, further detail is required in order to establish whether these obligations run concurrently, what the differences might be and which might take precedence. This detail is lacking within the Government’s proposals for a statutory duty. Moreover, the prospects of implementing a statutory duty of candour seem still to be uncertain when this option was rejected within a recent Government-commissioned report,\textsuperscript{531} the impact of which is yet to be seen.

\textsuperscript{528} Ibid.
\textsuperscript{530} Ibid., p18.
A weakness in the Government’s proposal for a statutory duty of candour results from the obligation being directed, not at individual practitioners but at an organisational level. This is insufficient because of the importance of placing responsibility to report appropriately and respond to medical errors at the ‘front line’ of health care, to those providing the care. This means there is consideration of the patient’s rights rather than organisational factors in disclosing medical errors. Placing patients’ rights at the centre of this legal responsibility is important as it underscores rights such as respect for patient autonomy. In any configuration of a statutory duty of candour there also needs to be a requirement for cooperation both at an individual and organisational level in being open in any investigation of such errors. This should co-exist with a duty to report such errors through national reporting and governance mechanisms.

### 6.13 Legal sanctions

The Mid-Staffordshire recommendations anticipate that non-compliance with a statutory duty of candour will be subject to criminal rather than civil legal sanction. Yet further explanation is needed in terms of how the statutory duty might be enforced. I suggest that a statutory duty of candour would most effectively be enforced by way of a tortious action for breach of statutory duty. Whilst statutory duties do not commonly give rise to redress in the civil courts when breached, it is possible for claimants to bring proceedings where it can be established that the statutory provision was intended to create civil liability, for which damages awarded for, amongst other things, psychological harm resulting from the potential anxiety and distress of not being informed, would be appropriate.

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534 An example of existing statute which has given rise to the possibility of claims in civil proceeding is the ‘Protection from Harassment Act 1997’.
Arguing for the need for a clearly defined legal duty to disclose for ‘emergent medical risks’ to patients in North America, Hafemeister and Spinos suggest that this sends a clear message to physicians in relation to the requirement to disclose. Indeed, they assert that, ‘physicians may take the duty to disclose more seriously when it is freighted with legal consequences’. This is an important issue as the measure of response of non-compliance underlines the seriousness of the obligation of a duty of candour. In contrast, the Government’s proposed statutory duty of candour, published in response to the Mid-Staffordshire report displays a clear reluctance to introduce criminal sanctions upon health care professionals on the front line who do not comply with such a duty. The reason for this lies in the concerns that individual criminal sanctions might, ‘unintentionally create a culture of fear’ which might ‘prevent lessons being learned and could make services less safe’. Although the Government acknowledges that ‘robust action should be taken’ in circumstances when staff deliberately breach fundamental standards of care or are obstructively dishonest, the nature of this censure is unclear and further clarification needs to be forthcoming.

The Government’s reluctance to impose criminal sanctions on health care professionals contributes to the recent discourse on the will of Parliament and the judiciary to criminalise the actions of health care professionals when fundamental standards of care have been breached. Criminal law has, over recent years, come to play an increased part in regulating the medical profession

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535 An emergent medical risk is defined as circumstances when a physician may discover or cause a medical condition that could result in material harm to the patient by T. Hafemeister, S. Spinos, ‘Lean on me…. A physician’s fiduciary duty to disclose an emergent medical risk’, Washington University Law Review. 86 (2009): 1167-1210 at 1168.

536 Ibid. p1182.

537 Ibid. p1182.


539 Ibid. p46.

540 Ibid. p46.

541 Ibid. p46.

542 For example see O. Quick, ‘Medicine, mistakes and manslaughter: a criminal combination?’ The Cambridge Law Journal. 69 (1) (2010): 186-203. However, this topic is beyond the scope of this paper which is confined more narrowly to the disclosure practices after a medical error has occurred.
and determining moral and ethical conflicts.\textsuperscript{543} As such, it is recognised that ‘the privileged and haloed status that medical practitioners previously enjoyed no longer protects them from civil and criminal liability’.\textsuperscript{544} Despite this, the criminal law in England still only plays a limited role in holding health care professionals to account for failures in care.\textsuperscript{545} One of the values of the use of criminal law results from its ‘symbolic and deterrent effects’.\textsuperscript{546} Criminal sanctions for non-compliance with a statutory duty of candour, by their very existence and the potential for conviction, give a distinct signal that this behaviour is not acceptable and damages the fabric of trust between patients, health care professionals and health care institutions. The concerns regarding fear that criminal censure might provoke can be mitigated. It is important to clearly communicate that criminal sanctions are not directed at an individual in order to attribute blame and punishment because an error has occurred, but that they exist in order to prevent a cover-up of the error.

6.14 Third parties

An area which merits consideration is the scope of a statutory duty in terms of how it relates to third parties, other than the patient. This is important in the context of medical errors as there will be instances when information disclosure cannot take place with the patient, for example, when the patient lacks capacity or is deceased. Within the Mid-Staffordshire recommendations the duty to inform is owed to patients and ‘other duly authorised persons’.\textsuperscript{547} However, the Government response to the Mid-Staffordshire report fails to address this


Further detail is required as to whom this person might be, why this is important, who provides the authorisation and at what stage in the patient’s care this authorisation would be sought or the person nominated, for example at the beginning of any care episode or after medical error has occurred. The reach of the statute should include that in the event of a patient sustaining a medical error and dying, or lacking capacity, either from pre-existing conditions or directly as a result of the error then the patient’s ‘duly authorised person’ should be informed that an error occurred. Although this provision may raise concerns about increasing levels of litigation as a result of this duty being extended to third parties, this can be partly mitigated by qualifying what is meant by ‘duly authorised person’. Nonetheless, extending this statutory duty to third party claimants, no matter how they are defined, has financial implications. This potential financial burden must be acknowledged yet it does not diminish the ethical justifications for the place of a duty of candour in the disclosure of medical errors.

Various options have been considered in relation to how a statutory duty might be incorporated into existing legislation. In 2012, a year before the publication of the Mid-Staffordshire Final Report, a proposal was defeated in the House of Lords which considered amending the Care Quality Commission (CQC) registration regulations to include the requirement for organisations to inform patients and their families of those who are affected when a medical error occurred. The suggested amendment intended to introduce a statutory duty of candour for all registered health care providers with the CQC to be open with patients when things go wrong and harm is caused. This proposal for a statutory duty was aimed at health care organisations rather than individual, registered practitioners. Yet, what this configuration of a statutory duty provides, which is lacking in other models, is detail in relation to the level of harm the patient must

549 Ibid. p104.
550 Existing CQC procedures require anonymous reporting of incidents causing injury to patients to the NRLS. This mandatory reporting is confined to incidents where ‘serious harm’ has come to the patient. Notably, this does not extend to a requirement to inform patients and/or their families of such incidents.
sustain for such a duty to be enacted. To date, the proposals for a statutory duty of candour have confined themselves to situations where the error has caused ‘serious harm or death’. Notably, this proposed amendment went further in articulating the level of harm to include: impairment to sensory, motor, or intellectual functions not likely to be temporary; changes to the structure of a patient’s body; the patient experiencing prolonged pain or prolonged psychological harm; the significant shortening of life expectancy of the patient; or any injury to a patient, which in the reasonable opinion of a health care professional, requires treatment by that, or another health care professional, in order to prevent death of the patient or injury to the patient which if left untreated would lead to one or more of the previous outcomes. This proposed amendment was limited to recognising a ‘duty to ensure openness and transparency with patients when things go wrong’. Further detail is required in current proposals for a statutory duty of candour as to how serious harm is defined, alongside debate as to whether the statutory duty be extended to moderate or mild harm, and how these are described. Given the ethical underpinning for disclosure of medical errors to patients it is inconsistent to focus upon a statutory duty only being imposed in circumstances of serious harm or death. The ethical justifications which support the need for a duty of candour exist in relation to medical errors notwithstanding the level of harm a patient incurs.

6.15 Conclusion

This paper has established that a duty of candour is based upon the fundamental importance upon respect for patient autonomy and provision of


553 Ibid. However, the obligations which may exist within a duty of candour to 'third parties', such as patient relatives, in the event of incapacity or death of the patient was not considered.
information. In order to progress and contribute to the debate on how best to encompass a duty of candour in law this paper has critically analysed existing proposals. Ultimately, a statutory duty of candour should represent a universal requirement on all health care providers, at an individual registered practitioner and organisational level. This universality to all patients receiving health care is consistent with a respect for patients’ rights in terms of autonomy in that it is an ideal owed to all patients. Moreover, a statutory legal duty of candour sends a clear message that addressing information disclosure after medical errors is a priority, both in political and health care spheres. The will to legislate and impose sanctions for non-compliance influences the response of health care providers to the issue. As such any statutory duty must encompass criminal sanctions for failure to comply. It is clear that patients wish to be informed when medical error occurs and it is no longer acceptable to paternalistically withhold this information. The political and social revulsion towards instances where wrong-doings have been ‘covered up’ in the health care context represents an opportunity for reform and a greater level of transparency when medical errors occur. Although this paper represents a starting point, given the relative lack of discourse on the detail of such a statutory duty further analysis, consultation and dialogue is required in order to carefully define how this duty is framed.
Chapter Seven
How should a nurse approach truth-telling? A virtue ethics perspective

7.1 Abstract

Truth-telling is a key issue within the nurse-patient relationship. Nurses make decisions on a daily basis regarding what information to tell patients. This paper analyses truth-telling within an end of life scenario. Virtue ethics provides a useful philosophical approach for exploring decisions on information disclosure in more detail. Virtue ethics allows appropriate examination of the moral character of the nurse involved, their intention, ability to use wisdom and judgement when making decisions and the virtue of truth-telling. It is appropriate to discuss nursing as a ‘practice’ in relation to virtue ethics. This is achieved through consideration of the implications of arguments made by Alasdair MacIntyre who believes that qualities such as honesty, courage and justice are virtues because they enable us to achieve the internal goods of practices.

7.2 Key words

Truth-telling; virtue ethics; nursing; nurse-patient relationship; professional practice.

7.3 Introduction

Truth-telling has been recognised as a key issue in bioethics and has been considered from philosophical, professional and ethical perspectives. This

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paper will focus on truth-telling within the dynamics of the connection between nurse and patient. The therapeutic nature of this nurse-patient relationship is a central concept in nursing. Within this bond issues such as truth-telling, compassion and communication are important. Nurses are often involved in discussions with patients that require decisions to be made regarding information disclosure. However, these discussions can be complex. Decisions will be made in a number of ways, by reference to legal and professional frameworks, by experience or intuition or by guidance from others. These mechanisms are useful to aid decision-making in relation to truth-telling. However, there also needs to be further consideration of the philosophical framework used and the moral reasoning required to make such judgements.

The complexities surrounding truth-telling can best be illustrated in the context of a real-life scenario: a critically ill patient in the last hours of their life. The patient asks the nurse looking after them, ‘Am I dying’? Many nurses respond intuitively to this situation depending on their professional experience in dealing with similar situations. This scenario raises a number of questions in terms of the nurse’s response, does she: opt for full disclosure and explain sensitively the inevitable consequences of the patient’s condition? Avoid the issue and make vaguely comforting statements? Ignore the patient’s questions, or reflect them back to the patient? Lie – by omission or commission – and deny the fact that the patient is dying and/or focus on the imagined prospects for recovery? I will advocate the use of virtue ethics as a philosophical approach to inform issues of information disclosure. This is because virtue ethics allows an analysis of the moral character of the nurse involved, their intention, ability to reason morally and the virtue of truth-telling.

7.4 Virtue Ethics

Virtue ethics focuses on the moral character of the agent, how the agent exercises the virtues and how they live their life. In considering how the nurse
should act in this situation it is important to identify what the appropriate virtues are and consider how the virtues contribute to the nurse making morally good decisions.

Many influential contemporary philosophers have discussed virtue ethics.\textsuperscript{555} There is a range of emphasis in and interpretation of virtue ethics within this body of work. It will be a neo-Aristotelian perspective along with modern philosophers’ interpretations of strong virtue ethics\textsuperscript{556} that will form the perspective of virtue ethics for this paper. However, as Aristotle is arguably one of the founding influences of virtue ethics, appropriate reference to Aristotle will also be made within the paper. A strong view of virtue ethics embodies the belief that, ‘virtue ethics and the virtues are capable of doing all the work of ethics.’\textsuperscript{557} Strong virtue ethics is a single theory which needs no supplementation from other ethical frameworks.

7.5 The Virtues

First, I will define what is meant by virtues and discuss the appropriate virtues that a virtuous person should possess and exercise. There has been a great deal of discussion by philosophers writing on virtue ethics in the attempt to define ‘virtues’. For the purposes of this paper a virtue is, ‘a character trait, habitually performed, which disposes one to act, think and feel in morally excellent ways.’\textsuperscript{558} In relation to the scenario of the questioning dying person it is appropriate to consider the specific character traits which would help the nurse to act in a morally excellent way. It is also appropriate to consider what is meant by ‘morally excellent’. There has been considerable debate about which virtues


should be included in any list of essential virtues as well as whether or not the virtues exist as a hierarchy. Aristotle produced a list of virtues and vices. Aristotle produced a list of virtues and vices. Truthfulness is included in this list as the mean between the excess of boastfulness and the deficiency of understatement. Aristotle states that ‘falsehood is in itself bad and reprehensible, while the truth is a fine and praiseworthy thing’. He argues that the virtuous will speak the truth when nothing depends on it and will speak it all the more when something does depend on it. Falsehood is viewed as something dishonourable. As the mean of truthfulness sits on the continuum of boastfulness and irony or self-deprecation, it can be argued that this virtue has more to do with being ostentatious and boastful about oneself or one’s achievements and less to do with truth-telling within an end of life context. Nevertheless, it does show the emphasis Aristotle places on truthfulness being an appropriate virtue. As Aristotle was writing about virtues two and a half millennia ago in ancient Greece, it is also important to consider some more modern interpretations. Other philosophers, writing more recently, have also identified the virtue of honesty in their work. According to these commentators the virtue of honesty seems essential for the virtuous person. In our scenario the virtuous nurse would be an honest nurse and one that would have developed the ability to see the median without undue deliberation and thus be in a position to act in the right way, and to the right degree, in relation to honesty. In this sense moral action becomes a match between situation and principle. This is a situation that calls for truth-telling. This much seems clear, but it is worth analysing further, the extent to which virtue ethics does provide guidance on how to act, feel and think.

560 Ibid. p105.
7.6 Criticisms of virtue ethics

Various philosophers have identified and discussed the perceived shortcomings within virtue ethics theory.\(^{562}\) Indeed, one of the criticisms of virtue ethics is that it does not provide a clear set of rules or guidance for actions in different contexts. Critics of virtue ethics argue that it is not enough just to say that the virtuous person should act virtuously. The inclusion of different virtues with no established hierarchy of virtues leads opponents to argue that it is not helpful in complex situations where there may be competing virtues. Hursthouse\(^ {563}\) discusses this point and argues that virtue ethics can provide rules for action stating that each virtue generates a prescription and each vice a prohibition. These are referred to as v-rules. If this is applied to the scenario, then the virtue of honesty would require the nurse to do that which is honest and avoid that which is dishonest. This is because honesty is a virtue and dishonesty a vice. However, is it as simple as this? Within this situation there may be other competing virtues such as compassion. Therefore, it is important to be able to interpret the rules and decide how to act according to all the virtues. To do this one needs to be able to use reasoning and wisdom.

Critics of virtue ethics also argue that the central proposal in virtue ethics, that an action is right if it is what a virtuous agent would characteristically do in the circumstances, is circular in nature and a truism. They argue that this tenet only provides guidance for action if an individual is, and knows she is, a virtuous agent. Proponents of strong virtue ethics argue that having an idea of the virtues and v-rules provides a satisfactory account of what the virtuous person would do. This together with the ability to reason correctly about moral matters does indeed provide guidance for action.

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7.7 Moral reasoning and practical wisdom

Within the given scenario there are different courses of action available for the nurse. All of these may reflect differently on the moral character and reasoning of the nurse. At this critical point it is important that the decision-making process of the nurse involved is considered. How can the nurse decide what level of information disclosure there should be in this situation? What should guide the nurse when making this decision? The nurse certainly should act in accordance with the appropriate legal and professional frameworks. However, often such frameworks can only give general guidance and blanket statements that do not allow for the complexities of these decisions. Therefore, it is vital that in addition to these frameworks the nurse should have the ability to use reason and moral judgement within any decision-making process. This is in order to be able to make morally good decisions in relation to patients in different situations. The importance of practical wisdom (phronesis) is one of the areas emphasised in Aristotelian virtue ethics. Phronesis is an intellectual virtue without which none of the virtues of character can be exercised. For Aristotle, the virtue lies in the mean. It is by acting at the right point, or to the right degree, and for the right motives which is the mark of virtue. To make a judgement at the right point and right degree the nurse needs to possess and use moral reasoning.

However, will practical wisdom and reasoning always lead to a morally good decision or the morally right decision? This is worth examining in relation to ‘hard’ cases in the health care context. The emphasis on practical wisdom in virtue ethics is clear. Therefore, it is important to consider how practical wisdom can be developed. Aristotle makes the distinction between intellectual virtues, which are acquired through teaching, and the virtues of character obtained through habitual exercise. Moral education plays a central role in virtue ethics. A full exploration of how practical wisdom can be best taught, if it can, is beyond the scope of this paper. As there are both intellectual and moral virtues it is useful to consider how teaching and habituation combine within moral education. If intellectual virtues can be taught, and by teaching I mean the way in which

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knowledge is imparted from one generation to the next, then we need to think about how this can be done. Moral goodness, according to Aristotle, is the result of habit. We learn from exercising the virtues, for example, it is the way that we behave in our dealings with other people that makes us just or unjust. Aristotle explains that like activities produce like dispositions. It would be useful to analyse further the combination of teaching and habituation within the context of nurse education and the nursing profession.

Hursthouse discusses resolvable, irresolvable and tragic dilemmas. These are dilemmas and moral conflicts in which there is a conflict in virtues, in our case, perhaps honesty and compassion. As I have suggested there is no identified hierarchy of virtues to turn to. Therefore, it is vital to be able to use practical wisdom to decide what the virtuous person would do. In the example offered in this paper there may be reasons the nurse would withhold aspects of information in the attempt to avoid harm and distress to the patient and to try to preserve hope. In this case the virtue of compassion may be sufficiently important that the virtuous nurse used their practical wisdom to decide that it was a situation when even an honest person could withhold parts of the truth. There may also be reasons that the nurse would disclose fully the situation to the patient, believing that this is what an honest person would do. It may be that in this situation the nature of the truth is such that it outweighs other concerns. This is not to say that if the nurse decides to opt for full disclosure then she will abandon the virtue of compassion. The virtuous nurse would then deliver the information in a compassionate manner. It is also not sufficient to believe blindly that the nurse is morally good by withholding the truth in order to adhere to the virtue of compassion. Again, there needs to be wisdom used when considering the requirement to act at the right time, to the right degree, in relation to both honesty and compassion.

The nurse may deliberate over her course of action and feel unease at whichever decision she makes despite using her practical judgement and

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reasoning. Hursthouse\textsuperscript{568} describes this as the ‘moral remainder’. It is appropriate for the virtuous individual to feel emotions such as regret, guilt or remorse. These feelings come as a result of being aware of the complexities involved in moral dilemmas. Foot\textsuperscript{569} discusses in detail the question of whether the more virtuous person is the person who acts with ease choosing the virtuous course of action? Or whether the more virtuous person is the person who chooses the same course of action despite it being a harder decision for them? Hursthouse\textsuperscript{570} also explores this distinction. She concludes that there may be other things that make it hard for an individual to act well, other than potential deficiencies in their character. It may be that the circumstances are such that even the virtuous character is ‘severely tested’. For Aristotle the virtuous person acts virtuously because they are of good character. They act in the right way and choose the right things happily. However, it may not be as easy as that. In our situation the nurse may know that the right way to act is to tell the patient honestly the full truth and be fully committed to the virtue of honesty. Despite this the nurse may feel unease in having to impart this information to the patient. To illustrate this point it is possible to imagine a situation involving the son of this patient who has already spoken to the nurse explaining the reasons why, as he sees it, his mother should not be informed of the prognosis. The son claims to know his mother best and is certain that the effects of full disclosure would be devastating to her. The nurse may have explained, as can happen in practice, that she would not initiate the conversation, but, if asked directly, she would have to respond honestly. Within this situation even when answering the patient honestly the nurse may still have feelings of guilt for going against the wishes of the son and because of the uncertainly of the consequences of the information for the patient.

For Adams\textsuperscript{571} a virtuous character is not sufficient or indeed necessary to ensure right action. He describes an example: a businessman may deal honestly only because they fear dishonesty would damage their business, rather than acting

\textsuperscript{568} Ibid.
\textsuperscript{569} P. Foot, \textit{Virtues and Vices} (Oxford: Oxford University Press, 2002).
from being of virtuous character. Applying this to the end of life scenario the nurse might decide to withhold some information from the patient. This decision could have been reached for several reasons. One of these reasons could be that the nurse fears unfavourable repercussions from the patient’s son who might be angry to find that his mother had been informed of her prognosis in spite of his wishes to the contrary. Alternatively, perhaps the nurse is having a busy shift and does not have the time to discuss this issue with the patient. However, the same action of withholding information might be taken by the nurse but from different motivations. The nurse may decide acting to the right degree in terms of honesty, in this case, would mean withholding some information. This decision might have been reached after considering the situation using practical wisdom. The nurse may truly have reason to believe that full disclosure would significantly harm the patient. In both cases, the same action is taken but from different motivations. It is worth asking, if the result is the same in both cases, then do the reasons behind the action matter? This introduces the importance of motivation within virtue ethics.

7.8 Motivation

Many virtue ethicists emphasise the importance of motivation and acting from the appropriate dispositions for right action. Motivation is important within virtue ethics because of the focus on the moral character of the individual. Foot explores what it means to say that a person has a motive for action. It seems that motivation and intention are linked. Foot argues that intention in acting means aiming at a certain thing, and the motives for this action often mean the aim in doing the action. However, an important aspect of the link between motives and intention is that motives cannot be determining forces. One cannot be said to have the intention to perform an action if one is unwilling to carry out the steps required to achieve that goal. Slote discusses the distinction between doing the right thing and doing the right thing for the right reason. Taking an agent-based rather than agent-focused approach, he argues that the rightness of an action depends on the actual motivation that lies behind it. Slote


then attempts to rebut the claim that this makes it morally irrelevant what actions an individual actually takes, as long as the motives are good. He argues that acts are not virtuous just because they are performed by someone who possesses virtuous motivation, but the act also has to exhibit the proper motivation to count as virtuous. Hursthouse\textsuperscript{574} also emphasises that it is not enough just to act in certain ways, and that to possess a virtue one must also act in those ways for certain sorts of reasons. Therefore, it is important to consider the motivation of an individual as this reflects on their moral character.

Despite the importance of motive it is not enough on its own to ensure right action. Oakley and Cocking\textsuperscript{575} explore whether people with virtuous characters can sometimes be led by virtuous character traits to act wrongly. They give an example of relevance to this discussion that illustrates the point. The example involves a doctor withholding a diagnosis of terminal cancer from a patient but informing the patient’s family and asking them to join in the deception. The doctor may be acting out of the virtue of benevolence or compassion. However, in this case, even though the doctor is acting from good motivation, this does not seem to be enough to ensure right action. There also needs to be a practical component, in our case practical wisdom, which involves ensuring, as far as is possible, that the actions taken bring about that which virtue dictates. Oakley and Cocking\textsuperscript{576} question whether, in situations like this, the agent really does have the virtuous character trait which we are assuming they do. Alternatively, the individual may be lacking in another character trait which is relevant, in this situation, the character trait of honesty.

7.9 What is a morally good decision?

A further question that needs to be explored is, what is a morally good decision? It may help to consider how competing philosophical frameworks may approach this question in relation to the scenario. It is difficult to examine this question without turning to more outcome-focused philosophical frameworks calculating

\textsuperscript{576} \textit{Ibid}. 
the consequences for the patient and for the nurse. The nurse may make their decision based on what they feel the consequences of withholding information or full disclosure are to the patient. This may be in terms of predicted harm or distress to the patient, or effects on hope, autonomy and their decision-making ability. However, there are difficulties with this approach which are the well-rehearsed criticisms of outcome based philosophical frameworks. These include the difficulties of predicting consequences both in the short and long term and whether the nurse is able to make decisions about what is important to a patient based only on the patient’s own values. Having the rightness or wrongness of actions solely embedded in their consequences increases the level of uncertainty in decision-making. This is because of the difficulty in being able to predict consequences in any absolute sense. The best that can be done is to accept that there may be a range of consequences, with some being more probable than others. Therefore, in this situation the nurse may consider a range of possible consequences for the patient, and perhaps also for herself. She would then make a decision based upon what she believes to be the best course of action as determined by those consequences. Although virtue ethics is agent-focused rather than outcome-focused it is a teleological theory that cannot deny consequences.

Deontological frameworks can also be used to consider how the nurse can make a morally good decision. Truth-telling is supported by the best-known deontological perspective because one has a duty to tell the truth, and like every other duty this must be upheld. In Kant’s moral philosophy truth-telling fulfills the categorical imperative for universality. He writes, ‘Truthfulness is a duty that must be regarded as the basis for all duties founded on contract, the laws of which would be rendered uncertain and useless even if the least exception to them were admitted’. According to Kant, individuals must always reveal the truth irrespective of the consequences. Applying this absolute perspective to telling patients the truth means that there would be no exception to this rule. This framework does not allow for a consideration of the specifics of a situation or of

577 I. Kant, On a supposed right to tell lies from benevolent motives. Appendix in Kant’s critique of Practical reason and other works on the theory of ethics. (Trans by TK Abbott) (London: Longmans, Green and Co., 1923) p363.
the moral character and reasoning of the individuals involved. There is a danger that adhering to moral absolutes (such as truth-telling) in all cases may do more harm than good.\textsuperscript{578} Some philosophers, including Ross\textsuperscript{579} discuss duties in terms of being \textit{prima facie} rather than absolute. However, applying the absolute perspective to the given scenario the nurse would answer the patient giving full disclosure regarding the patient’s imminent death, and this would be without regard to the consequences for this patient.

As illustrated in the application of two of the more established philosophical frameworks of consequentialism and deontology, both provide some guidance of how to act in this type of situation. However, it is possible to imagine other situations involving unknown consequences where the dynamics are so complex that an absolute rule is unhelpful. Virtue ethics provides a useful alternative because it focuses on the moral character of the individual and on their ability to use practical wisdom. This means that however complex a situation might be, a consideration of the morally good decision can be made by the individual in relation to the virtues by the use of practical wisdom.

In the situation described, the patient has asked the nurse the question, ‘Am I going to die?’ It might be that their question is prompted by an awareness of the possibility that their death may be imminent. It might be felt that to answer this question honestly is to adhere to the virtue of honesty. However, not all patients will be prompted in this way to ask this particular question, leaving the nurse who is aware that the patient only has a few hours to live, with a different sort of decision with which to grapple. The patient may not ask the question for different reasons. It may be that they do not wish to know the answer, it may be that they do not realise their death is imminent or it may be that the patient does not know how to ask the right sort of question. Taking this into account the question, ‘Is it virtuous for the nurse to wait until the patient does ask the question?’ becomes of central importance. To answer this question it is necessary to further explore

\textsuperscript{579} W.D. Ross, \textit{The Right and the Good} (Reprinted with an introduction by Phillip Stratton- Lake) (Oxford: Oxford University Press, 2002).
the nurse’s role in such situations. In all probability the nurse will have a greater awareness and more knowledge about the clinical prognosis than the patient. This imbalance in knowledge between the patient and the nurse leads to some interesting questions in relation to the nurse’s role including the question: ‘Does the knowledge gained from the nurse’s professional standing impose a higher duty on the nurse to ensure that the patient is fully informed?’ It may be the case that the patient neither knows what or how to ask the appropriate type of question and this implies that responsibility for informing (or not informing) the patient lies with the nurse. These are issues about which the nurse should be aware when considering levels of information disclosure.

7.10 Nursing as a practice

In this paper the decision-making process of the nurse involved in a particular situation is being explored with the help of the virtue ethics approach. As one of the central questions in virtue ethics is, ‘What sort of person should I be?’ this merits further examination in relation to the individual involved, who, in this instance, happens to be a nurse. It is worthwhile considering Alasdair MacIntyre’s thesis in ‘After Virtue’ to try to begin to analyse these issues.\footnote{A. MacIntyre, After Virtue. A study in moral theory (London: Duckworth, 2007).} Within this work MacIntyre characterises virtues in terms of practices. This is relevant in this discussion as nursing has been proposed as a particular type of MacIntyrean practice.\footnote{D. Sellman, ‘Alasdair MacIntyre and the professional practice of nursing’, Nursing Philosophy 1 (2000): 26-33.} The core virtues identified by MacIntyre within a practice are the virtues of justice, courage and honesty.

MacIntyre, by analysing the various lists of virtues described through history, identifies the difficulty in compiling a consistent set of virtues owing to the different social, historical and cultural contexts of those writing about the virtues. MacIntyre argues that virtues need to be situated in relation to practices. He defines a practice as, ‘any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence,
which are appropriate to and partially definitive of that form of activity'.

MacIntyre argues that practices have internal goods attached to them, that is goods that can only be achieved by performing the practice and have value to the individual as such. This is differentiated from an activity that primarily has external goods attached to it. External goods mean that there are alternative ways of obtaining these goods other than by engaging with the practice, for example money or status. Sellman \(^{583}\) discusses nursing as a professional practice. He identifies that within the practice of nursing there are particular internal rewards such as the positive feeling associated with helping others and the long-term progression of engaging with the practice of nursing. The presence of these internal goods does not preclude the fact that there may also be external goods related to the practice, for example a wage. Sellman \(^{584}\) differentiates nursing as a professional practice as it requires commitment and continuing engagement to the care of a given individual(s) and to the tradition and enhancement of the practice of nursing. MacIntyre argues that virtues not only need to be situated in relation to practices, but also in relation to the good life. This ‘quest’ for the good to increase self-knowledge and knowledge of the good takes place against the narrative of our lives. The narrative unity of an individual’s life is important to MacIntyre. He argues that someone who genuinely possesses a virtue is expected to be able to exercise it in very different types of situation. Therefore, the individual should not just possess a virtue in relation to any particular role they play in society but there needs to be a unity of the character and the life narrative that the character exists within.\(^ {585}\)

This link from the practice of nursing to the conception of self in morality requires us to think about how the virtues the individual engaging with the practice of nursing possesses relate to the virtues that same individual exercises when not in the workplace practicing nursing. If these virtues are the same, then it is important to think about what virtues are significant both for the practice of nursing and for the individual in their life.

584 Ibid.
This brings about a third stage within which virtues need to be situated, that of tradition. For MacIntyre tradition is important as practices have a past, a present and a future. The fact that practices have histories influences the understanding of what that practice is. An individual’s ‘quest’ for their good is conducted within the context defined by those traditions of which the individual’s life is part. It is the virtues that sustain and strengthen traditions. It is important, therefore, that the virtues are consistent with the moral traditions of that practice and within the narrative unity of an individual’s life.

Through his thesis MacIntyre further develops what we mean by virtues in order to try and overcome the difficulties associated with defining the nature of virtues. Virtues can be understood as those, ‘dispositions which will not only sustain practices and enable us to achieve the goods internal to practices, but which will also sustain us in the relevant kind of quest for the good…and will furnish us with increasing self-knowledge and increasing knowledge of the good’. The importance of situating virtues within a practice, the quest for the good life (the narrative unity of an individual) and the tradition of that practice can be discussed in relation to nursing. As has been suggested nursing has previously been described as a particular type of MacIntyrean practice. While I cannot develop this line of thought fully here, I can, nonetheless, look at this more narrowly in relation to the scenario. If nursing is a practice then within this the nurse should exhibit the virtues of that practice which MacIntyre describes as the virtues of honesty, courage and justice. Therefore in relation to the scenario the nurse needs to be honest, so we would think the nurse should answer the patient honestly. An individual should not just possess the virtues within the role they play as a nurse in society: there should also be a unity between this and the life narrative that the nurse inhabits. If honesty is a virtue for an individual then it should also be a virtue for the individual when carrying out their role as a nurse. This can then be related to the moral traditions of the practice. The moral traditions of nursing have been discussed in many contexts. The UK code for nurses gives some indication of current professional and ethical standards of

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586 Ibid. p219.
Within this there is an emphasis on the patient’s right to accurate and truthful information. Insight into the moral traditions can also be gained by looking at both historical and contemporary writing on nursing. The nurse is part of the traditions within the practice of nursing therefore their moral character will need to be consistent with those traditions. This is important when we consider the relationship between the moral character of the individual and the moral character of that same individual carrying out a particular role in society.

7.11 Conclusion

This paper has argued that the philosophical approach of virtue ethics is of value, not only in terms of providing guidance regarding how to be, but also how to act. These issues have been examined within the context of a clinical scenario involving disclosure of information at the end of life. The scenario was used as a mechanism to explore the role virtues might play as the nurse decides how to answer the patient’s question, ‘Am I dying?’ Many nurses would answer this question intuitively, based on their experience of these types of conversations, or by reference to their own moral compass. However, it is important to be able to reflect more deeply on how decisions are made and the moral character of the individual involved. Intention has been emphasised as an important component of virtue theory. As Aristotelian virtue ethics is a teleological theory, the focus on intention and analysis of the appropriate motivating goals, aids in the analysis of moral character. Applying MacIntyre’s work to the scenario enabled further discussion of how virtues can be thought of in terms of practices, the narrative unity of an individual’s life and the moral traditions of that practice.

Chapter Eight

Conclusion

This thesis has critically examined the specific legal and ethical tools that require greater clarity to assist health care professionals in making decisions regarding information disclosure. To highlight the issues surrounding these questions and set them in the context of day-to-day health care practice, this thesis focused on three key areas: the concept of therapeutic privilege; the need for a legal duty of candour; and the utility of applying virtue ethics to issues of information disclosure. These areas were chosen as they illustrate some of the complexities around information disclosure from a legal and ethical perspective. In respect of each of these topics, this thesis concludes that there is an irrefutable need to resolve key issues surrounding information disclosure, notably the legal status of therapeutic privilege and the urgent need to establish a workable and enforceable duty of candour. In addition, this thesis establishes the efficacy of virtue ethics as a practical tool to analyse real world ethical dilemmas in clinical practice.

In this concluding chapter I aim to pull together the overarching conclusions from this research. In doing so I hope to consolidate the work in the substantive body of the thesis together with underlining the contribution it makes to the existing literature. In the second half of this chapter I underscore the originality of the approaches used within this thesis to examine issues of information disclosure.

8.1 Patient autonomy and Information provision

One of the central conclusions contained in this thesis is a further reinforcement of the well-established tenet that respecting patient autonomy is an important principle within contemporary health care. The importance of the principle of respect for patient autonomy is at the heart of each of the papers included in this thesis and is underpinned by the importance of information disclosure. More interestingly though, the specific cases chosen to focus upon in this thesis show that, both in theory and in practice, the primacy of patient autonomy in relation to
information provision can present challenges for health care professionals as a result of their concurrent obligations to act in the patient’s best interests.

This tension is played out particularly in relation to the extent to which the concept of therapeutic privilege is legally and ethically defensible within current health care practice. There is a need for a device such as therapeutic privilege as a result of a shift towards a standard of information disclosure measured by reference to the reasonable patient instead of the health care professional. Yet, the lack of legal clarity on the scope of this privilege undermines respect for patient autonomy. As the thesis continues, this subject is revisited as the importance of respect for patient autonomy provides a strong basis on which to build a legal duty of candour. Here, information is linked to respect for autonomy because in order to make decisions about gaining further health care, who should provide that care, and deciding whether to pursue legal recompense for any harm suffered, patients need to be informed that an error has occurred, alongside the nature of the error and any potential consequences. The existing legal vacuum, in terms of a lack of clarity on how this duty should be framed, presents a risk to the ideal of respect for patient autonomy. The subject of how information disclosure supports patient autonomy is returned to more implicitly in Chapter Seven. Here, in an account of how a nurse should approach truth-telling, the value of information disclosure is seen in the assertion that withholding information constrains autonomy as the patient may make, or not make, decisions which they would have if they had been informed.

As a result of this exposition, this thesis concludes that respect for patient autonomy is a fundamental justification to disclosure of information to patients. I recognise that health care professionals also need to be mindful of other obligations they hold towards patients, such as acting in the patient’s best interests and avoiding harm. However, I contend that in most circumstances withholding relevant information about their health is not in the patient’s best interests. Accepting that there could be circumstances in which this position might be tested, this leads to the conclusion that it is imperative that legal tools - such as therapeutic privilege - are carefully articulated.
A coherent theme throughout this thesis is the importance of trust within the health care professional-patient relationship and, in a wider context, in relation to trust within health care institutions. Trust is integral to these relationships and is based on the belief that there will be an open and honest exchange of information between parties. One of the main conclusions resulting from the examination of the legal and ethical tools in relation to information disclosure, is that there is a lack of clarity, particularly from a legal perspective, which risks undermining this trust. This is evidenced by the lack of explicit legal articulation of both therapeutic privilege and a duty of candour. Both legal devices give opportunities to provide clear legal regulation of instances when information can lawfully be withheld, and conversely the way in which the law compels information to be disclosed. I would argue that the obfuscation of these principles in law means a lack of clarity of the grounds on which disclosure decisions are made. This creates difficulties for both patients and health care professionals. Patients are compromised in the sense that it is unclear what level of disclosure they may expect, and when disclosure practices fall outside this norm. Health care professionals face difficulties as a result of the blurring of legal boundaries in terms of the scope and detail of these obligations. This level of uncertainty, both from the perspective of patients and health care professionals, has the potential to erode trust within the patient-health care professional relationship. Therefore, it is incumbent on those providing legal and professional regulation of the health care profession that there is clarity and legal oversight in order to support a health care system that values trust.

In order to fully address these conclusions in terms of recognising the significance of patient autonomy and trust in the context of information disclosure this thesis recommends a multi-disciplinary analysis into the validity of therapeutic privilege in the English context and its legal, ethical and professional implications. Moreover, further exposition is required on the scope and framing of the legal position of a duty of candour in English law. This is required in light of the different recommendations given by Government commissioned reports
and statements together with the unanswered questions as to how a legal duty contained in contract and in statute might interact.

8.3 Applying theory to practice

This thesis has concerned itself with the practical application of information disclosure in clinical practice in order to illustrate how theoretical concepts might work in clinical practice. This applied approach exposes the gaps in knowledge and potential inconsistencies which impact on the way health care professionals make decisions in relation to information disclosure. This was evident in the analysis of therapeutic privilege within clinical practice which revealed a need for further articulation of its scope and application. Moreover, in terms of establishing a duty of candour in law, in circumstances when medical error has occurred, it is evident that further research is required to establish the best way to create this legal principle - and how it will be framed in terms of its obligations and sanctions. The analysis of a nurse's decision-making process when faced with an ethical dilemma in clinical practice was given an applied perspective by using a theoretical ethical approach and applying this to the truth-telling scenario. Taken together, this applied approach provides greater relevance to the practice of health care professionals as it concerns itself with decisions that happen in real world clinical practice. This technique also aims to further the debate in how theoretical ethical and legal concepts are applied to practical questions of information disclosure. In order to further this endeavour, additional application of virtue ethics, together with a consideration of how this ethical theory might be complemented by other ethical approaches, is required.

8.4 Interdisciplinary approach

This thesis aimed to demonstrate the value of exploring issues in health care by synthesising a legal, ethical and professional approach in order to build a wide-ranging narrative around information disclosure. This was an important and original methodological approach that demonstrated how the spheres of ethics, law and professional issues interact to provide insights into clinical problems. This interdisciplinary approach can be seen throughout the thesis as each of the
main research questions were analysed from legal, ethical and professional perspectives. By taking this approach, I was able to offer a more comprehensive discussion which critically analysed how each of these disciplines act at times in concordance and at other times with a degree of inconsistency. An example of this is found in my consideration of the interplay between professional guidance and the law in relation to disclosure of information. Here, in an analysis of the medical guidance, I conclude the standards expected by the profession are more exacting than the law, which is problematic. It is important from the perspective of both the patient and the health care professional that a greater level of consistency is required in order to provide more clarity of what is expected to meet the standards of disclosure required, legally and professionally.

A further example of how this approach illustrates some of the tensions between ethical and legal norms of disclosure is in the context of therapeutic privilege. Here, the exposition of the ethical justifications for disclosure of information to patients reveals a tension in having a legal exception to this norm. By emphasizing these arguments side by side, I have been able to argue for a greater legal articulation of therapeutic privilege.

This thesis provides an innovative analysis of issues of information disclosure by applying this interdisciplinary methodology to spheres of inquiry which have hitherto received little or no analysis from this perspective. Overall, this approach provides an opportunity to dissect clinical questions in relation to information disclosure using ethical and legal arguments whilst ensuring that the professional requirements practitioners need to abide by remain at the forefront of the dialogue. This technique of synthesising the knowledge and insights gained from different disciplines to questions in Bioethics reflects a contemporary trend in the discipline. This approach acknowledges that in clinical practice these domains do not operate in isolation. By considering questions in Bioethics, in this case focusing on information disclosure from an interdisciplinary perspective, it allows for a response that can reflect a greater understanding of the myriad of rules, obligations and guidance which impact on the decision-making of health care professionals. As such, more realistic, nuanced answers can be provided to important questions which impact on
clinical practice and the experience of health care provision by patients.

8.5 Focus on nursing

The interests, insights and perspectives of nursing staff from legal, ethical and professional perspectives when confronting issues around information disclosure have been central to this thesis. This is an important perspective as, in comparison to medicine, the position of nurses facing dilemmas of information disclosure has received little analysis from an interdisciplinary approach. I have been particularly interested in the nurse’s position as part of the health care team, together with how nurses might make decisions regarding information disclosure. The question of the legal position of the nurses in relation to instances when therapeutic privilege is invoked is discussed in Chapter Five. Here, I conclude that the nurse is in a precarious position as to whether the privilege extends to the rest of the health care team. This requires further explicit legal articulation in relation to how this privilege relates to the whole health care team given the emphasis on a multi-disciplinary approach to health care. Furthermore, the decision-making process of the nurse when faced with a clinical scenario regarding information disclosure was analysed in Chapter Seven. I advocated the use of virtue ethics as an approach from which to guide decision-making. This was based upon the merits of virtue ethics in explicitly valuing the importance of the moral character of the nurse, the role of emotions, clinical judgement and moral reasoning. Ultimately though decisions in clinical practice are made using a pluralist range of guidance. The influence of considerations on how to act from other ethical theories together with legal and professional guidance all reinforce the importance of understanding an interdisciplinary approach to clinical practice.

8.6 Future directions

The thesis has provided the opportunity to explore the legal and ethical tools relating to information disclosure which require further articulation and application in order to assist the decision-making of health care professionals. I have focused upon three specific areas: therapeutic privilege, duty of candour
and the application of virtue ethics to truth-telling. This investigation has afforded a range of possible future directions for this research. In the following section I would like to explain two particular areas which would further the themes present within this thesis: a greater engagement from an empirical perspective of the importance of moral virtues in clinical practice for nurses; and further analysis of how a team approach to health effects decision-making in relation to information disclosure.

The application of virtue ethics to the decision-making process of the nurse in respect of information disclosure provided an interesting starting point to advocate for the value of applying virtue ethics to clinical practice. This foundation could be built upon by providing an analysis of some of the virtues which might be considered an important part of the moral character of the nurse in order to practice nursing well. One such example of this is compassion. The work in this thesis provided the background to be able to embark on a research project which examined the perceptions of health care professionals and health care students on the role of compassionate care in clinical practice. This research project not only built upon the themes of moral virtues within clinical practice but also further emphasised the value of the methodological approach within this thesis. This is evidenced by the use of a mixed-methodology empirical approach together with a focus primarily on the perspective of nurses. This research project has produced a paper which has been published as well as a paper currently in journal review process. The findings of the published paper indicated that there was a high level of consensus in relation to the participants’ understanding of compassion in health care. Despite some ambiguity on whether compassion is an innate quality or one that could be learnt, it was concluded that it is essential for professional values, including care and compassion, to be at the core of nurse education.

589 L. Bray, M. O’Brien, J. Kirton, K. Zubairu (nee Hodkinson), A. Christiansen, ‘The role of professional education in developing compassionate practitioners: a mixed methods study exploring the perceptions of health professionals and pre-registration students’, Nurse Education Today Article in Press. Published online 23rd July 2013
A further area which merits closer examination is to investigate the extent to which a team approach to health care provision affects decision-making around information disclosure. By focusing upon this area, insights could be gained of the dynamics within the health care team when decision-making happens. Here, further investigation of who makes decisions, how are they made and communicated through the team, what happens when there is conflict between members of the team and how could these process be improved would be interesting. A qualitative empirical approach to this investigation would yield the perspectives of the professionals involved. Here, I would hope to focus particularly on the position and dynamics between the doctors and nurses within the team. This research would aim to further dissect the decision-making process which takes place from a health care team perspective.

8.7 Recommendations

These conclusions lead to recommendations which aim to develop information disclosure practices in respect of the three central research questions:

1) A multi-disciplinary analysis needs to be conducted of the validity of therapeutic privilege in the English context and its legal, ethical and professional implications. As such this analysis should be undertaken in a joint initiative with representatives from the judiciary, health care professionals and their governing bodies, patient groups and academia.

2) Further exposition is required on the scope and framing of the legal position of a duty of candour in English law. This is required in light of the different recommendations given by Government commissioned reports and statements together with the unanswered questions as to how a legal duty contained in contract and in statute might interact.

3) Further application of virtue ethics, together with a consideration of how this ethical theory might be complemented by other ethical approaches, is required. This discourse should be present both within the academic
literature and the education of health care professionals. The endeavour of incorporating ethics training into both the pre-registration and post-registration training of health care professionals is important to help encourage more ethically sensitive clinical practice and as such needs to be an explicit part of the education programme for health care professionals.
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Appendices

The published versions of original articles:

The Need to Know—Therapeutic Privilege:
A Way Forward

Kate Hodkinson

Abstract Providing patients with information is fundamental to respecting autonomy. However, there may be circumstances when information may be withheld to prevent serious harm to the patient, a concept referred to as therapeutic privilege. This paper provides an analysis of the ethical, legal and professional considerations which impact on a decision to withhold information that, in normal circumstances, would be given to the patient. It considers the status of the therapeutic privilege in English case law and concludes that, while reference is made to circumstances when information (primarily in relation to risk disclosure) may be withheld, further clarification is required on the status of therapeutic privilege. I suggest there has been shift in English law relating to the standard of information disclosure towards one set by the test of the reasonable, prudent patient. It is this shift that necessitates the existence of a therapeutic privilege which enables doctors to withhold information that would usually be given to the patient in order to prevent serious harm. I then explore the professional guidance in relation to information disclosure and how this relates to the legal position. There are strong ethical arguments in favour of disclosure of information that would usually be given to the patient in order to prevent serious harm. In light of these, further clarification is required to identify and define the grounds on which this exception exists, the information that could lawfully be withheld and how this exception extends to rest of the health care team, particularly nurses. As such, explicit ethical and legal scrutiny of therapeutic privilege is needed in order to consider how this concept might be articulated, constrained and regulated.

Keywords Doctor-patient relationship · Health care team · Information disclosure · Therapeutic privilege · Truth-telling
Introduction

‘The relationship of information disclosure to the standard of medical care has been, and still is, perhaps the major focus of developing medical law’ [54, p 299]. The communication of information is a well-recognised and essential part of the relationship between the doctor and patient. It is also central to the process of obtaining consent. For some patients, it has been suggested that it may not be appropriate to disclose particular information due to the need to avoid the potential distress and harm that may result. This exception has been termed ‘therapeutic privilege’ and refers to withholding information from the patient which is considered to be a potential danger to the patient’s well-being [20, p 199]. Information is withheld during the consent process in the belief that its disclosure would lead to harm or suffering of the patient [26, p 155]. Thus, information a competent patient would ordinarily be told is deliberately withheld for the patient’s benefit, as it is perceived by the doctor [48, p 146]. However, as Brazier and Cave [13, p 118] suggest, ‘this defence needs to be based on cogent reasons relating to the welfare of that particular patient’.

This paper provides an analysis of the ethical, legal and professional considerations impacting on decisions made by doctors to withhold information from their patients. Firstly, I outline the ethical arguments in favour of therapeutic privilege. This is a controversial area; since many consider that anything less than the standard of disclosure required by law as an example of unacceptable paternalism. This opinion is perhaps unsurprising given the prominence of patient autonomy within contemporary health care. However, like many controversial subjects it requires further consideration of when, and if, this practice can be ethically and legally justified. Secondly, I consider the status of therapeutic privilege in English case law and conclude that, while reference is made to therapeutic privilege and its use in other jurisdictions further explicit consideration is required to examine the limits of such a privilege, the circumstances that it could validly be invoked and to whom does the privilege extend within the health care team. I suggest that there has been shift in English law to standard of information disclosure set by the test of the reasonable, prudent patient. It is this shift that necessitates the development of therapeutic privilege in English case law. However, there are powerful ethical arguments in favour of disclosure of information to patients. Given the strength of these arguments further ethical and legal scrutiny of therapeutic privilege is required in order to ensure that it is narrowly defined, used appropriately and is consistent with legal and professional guidance. This further articulation of therapeutic privilege could be achieved through consultation between the judiciary, the medical profession and patient group representatives to produce clear guidance on its use.

Ethical Justifications for Therapeutic Privilege

Whilst the notion of withholding information from competent patients is controversial in contemporary health care, an analysis of therapeutic privilege demands
consideration of the relative weight of ethical justifications in favour of its use.\textsuperscript{1} Several authors have explored the moral reasoning involved in considering difficult ethical judgements regarding the validity of the use of therapeutic privilege. In doing so they have identified processes which may help to establish whether deceiving the patient may be morally permissible \cite{67, 72}. Furthermore, empirical studies have examined doctors’ attitudes towards the use of deception in clinical practice \cite{27}. There are various philosophical concepts related to the notion of information disclosure. These include truth-telling, concealment, telling half-truths and withholding information.\textsuperscript{2} Whilst it is beyond the scope of this paper to analyse each of these terms it is important to recognise that, in practice, sometimes the boundaries of these concepts are blurred and there may be differing moral distinctions and interpretations of each. The most common and perhaps the strongest reason for not telling the truth is to protect others from harm—to protect patients from harm or distress. This perception of harm might even extend to the effects of a loss of hope. There may also be concerns that the patient might refuse to continue with therapy once they are given particular information. In addition, given the individual nature of patients and the complexities of care, some argue that an absolutist approach to truth-telling is not often helpful in the health care setting \cite{5}. This supports the need for an exception to information disclosure which the doctor could invoke without professional and legal censure in cases when the patient is at serious risk of harm from disclosure. Examples of this type of harm might include psychological and emotional harm which affects the patient’s physical condition and ability to make decisions. Maclean identifies that, in principle, therapeutic privilege ‘should only apply to situations where disclosure would harm the patient or make them so distressed that a rational decision is no longer possible’ \cite{51}, p 183]. It is useful to think of the clinical setting and how these principles within information disclosure may operate in practice. Brazier and Cave \cite{13} consider a possible clinical scenario and question whether a defendant surgeon might be able to rely on a defence of therapeutic privilege. They ask, in relation to a very elderly patient who the surgeon failed to warn of a small risk of impotence, whether this could be justified by saying, ‘the patient is highly nervous and exaggerates risks. If he does not have the surgery he will be doubly incontinent and have to go into a home. I just don’t think he could cope with the information’ \cite{13}, p 118]. Of course, it would be for the court to decide whether, given the circumstances of the case, this subjective, professional judgement of the surgeon could be justified and the use of therapeutic privilege supported. Notwithstanding the clinical situation, when therapeutic privilege is considered it should only apply to ‘specific items selected by the doctor for specific reasons’ \cite{55}, p 398]. Therefore, it is limited to that particular patient and their individual circumstances. Although the content of information itself is important, further consideration also needs to be given as to

\textsuperscript{1} Withholding information is linked to the dialogue on truth-telling. For a literature review on truth-telling see \cite{75}. For an overview of notions of trust and honesty in medicine see \cite{46} and for an overview of the ethics of truth-telling see \cite{37}.

\textsuperscript{2} For further discussion of the related concepts to the notions of information disclosure and definitions of each of these terms see \cite{8} and \cite{46}. In particular see Chap. 7 ‘Deceptions and concealments in medical and nursing practice’ in \cite{46}, p 94.
how that information can be conveyed. The manner by which information is disclosed to patients and ensuring good practice within this communication process is vital. The doctor must critically reflect whether all possible steps have been taken to consider how the information could be given to the patient in order to minimise and avoid any potential serious distress and harm.

Issues surrounding information disclosure exist within a wider context of the doctor-patient relationship. Within this there may be potential tension between the doctor’s duty of disclosure and obligation to act in the patient’s best interests. The duty to act in the best interests of patients, including doing no harm, may validate withholding information. Indeed, determining what information might be in a patient’s best interests to disclose or when there may be circumstances when withholding particular information might be more favourable could be viewed as part of the doctor’s duty to exercise clinical judgement. Doctors have to balance an obligation to provide information to patients with the knowledge that it may cause severe distress, anxiety and harm. So whilst honesty is generally desirable, it might not always be the best policy. This is because the duty to tell the truth is not absolute and can be outweighed by other moral considerations such as the obligation not to cause great and avoidable harm [73]. However, it has been recognised that both those for and against information disclosure, in cases where therapeutic privilege may be relevant, appeal to a ‘harm-benefit’ calculus to support their position [73, p 2]. The practice of withholding relevant information from patients without their knowledge or consent creates a conflict between concurrent obligations to protect patients and promote their welfare with parallel obligations to be truthful and provide relevant information, thus respecting a patient’s autonomy [11]. However, in extreme examples this potential harm to patients may be considered as so serious that it provides the moral justification to support withholding that information. This position has proved controversial and has led to analysis of the arguments given for restricting information disclosure.³

Much has been written on the topics of beneficence, autonomy and paternalism and how each of these concepts interact, alongside their philosophical underpinnings. Each of these issues are relevant when considering why philosophically the issue of information disclosure, and any exceptions to it, is one which the law should address. Here, I do not intend to attempt to capture these arguments as this paper is focussed more narrowly on legal and professional perspectives of information disclosure. I hope merely to identify the relevance of these philosophical issues to the issue of therapeutic privilege. The principle of beneficence, the duty to act to benefit the patient, is key within any justification of therapeutic privilege. Maclean identifies that, ‘although the obligation to benefit the patient seems intuitively a good thing, it is important to determine the limits of the duty and consider how it interacts with the obligation to respect autonomy’ [51, p 49]. Thus, in withholding information the doctor needs to consider how this affects the patient’s autonomy. A related concept, paternalism, is also relevant to therapeutic

³ See [14] for further discussion. A summary of Buchanan’s arguments critiquing the potential harm resulting in disclosure is provided by [59, pp 84–85]. For a more detailed discussion of these issues see [58].
privilege. Beauchamp and Childress define paternalism as, ‘the intentional overriding of one persons known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefitting or avoiding harm to the person whose preferences or actions are overridden’ [4, p 178]. They go on to discuss withholding of information in the context of ‘justified strong paternalism’ listing the conditions which would need to be satisfied for it to be viewed as such [4, p 186]. They identify the problem of medical paternalism as that of ‘rightly specifying and balancing physician beneficence and patient autonomy in the patient-physician’ relationship [4, p 187]. Taking into account the different obligations that doctors owe their patients in terms of respecting autonomy and acting in the patients best interests is complex and requires the use of professional judgement. Consequently, any decision to withhold information on the grounds of therapeutic privilege requires the doctor to consider the ethical underpinning of his actions in addition to the required professional and legal standards of practice.

Legal Position

The standard of information disclosure required by English law to obtain consent was considered in Chatterton v Gerson and another [17]. Here, as long as ‘the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass’ [17 per Mr Justice Bristow at 265]. This underscored the distinction between treatment given in the absence of any consent which would be dealt with as a battery, and consent given on the basis of inadequate information which would have its remedy in negligence. Alongside this, a doctor is required as part of his duty of care to his patient to warn the patient if there is ‘a real risk of misfortune inherent in the procedure, however well it was carried out’ [17 per Mr Justice Bristow at 258]. Albeit obiter, these comments introduced the important question of how to define risk which is material to the patient.

The House of Lords considered the standard by which a doctor should be judged when warning his patient of risks in Sidaway [70]. The majority opinion confirmed the Bolam [9] standard as the test of a doctor’s duty to warn the patient of risks, requiring the doctor to act in accordance with practice accepted by a responsible body of medical opinion. Lord Scarman dissented from this view suggesting that the standard of information disclosure should be assessed by reference to what the objective, reasonable, prudent patient would wish to know. He disagreed with the extension of the Bolam test from decisions relating to diagnosis or treatment, to decisions regarding risk disclosure [70 per Lord Scarman at 649]. In his view, the patient’s right to make his own decision was viewed as a basic human right.

4 Although Beauchamp and Childress caution that justifying paternalistic actions by assigning an overriding status to either respect for autonomy or beneficence is overly simplistic and can be seriously misleading’ [4, p 187].

5 Mr Justice Bristow emphasises that ‘if the information is withheld in bad faith, the consent will be vitiated by fraud’ [17 per Mr Justice Bristow at 265].
The standard for risk disclosure should not be what the medical professional thinks is appropriate, but what the average, prudent patient would want to know [70 per Lord Scarman at 654]. A doctor would therefore be liable if he omitted to inform a patient of a risk which, in the court’s view, was such that a prudent person in the patient’s situation would have regarded it as significant [70 per Lord Scarman at 654]. However, Lord Scarman acknowledged the role of therapeutic privilege and he cited, with approval, the American case of *Canterbury v Spence* [15]. As defined by that case, therapeutic privilege enables a doctor to withhold information from his patient regarding risk if it can be shown that a reasonable medical assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient [15]. Lord Scarman argued that it is,

plainly right that a doctor may avoid liability for failure to warn of a material risk if he can show that he reasonably believed that communication to the patient of the existence of the risk would be detrimental to the health (including of course, the mental health) of his patient [70 per Lord Scarman at 654].

This plea for the prudent patient standard, subject to a therapeutic privilege ‘exception’, was not followed by Lord Scarman’s fellow judges. Though there was no further explicit reference of therapeutic privilege, there was an acknowledgement that there may be circumstances when information that would normally be disclosed by a doctor in the exercise of his responsible clinical skill, may be withheld. Lord Templeman recognised, for example, that the obligations relating to information disclosure should be weighed between, on the one hand, having regard to the best interests of the patient and, on the other, making sure sufficient information is available to the patient in order to reach a balanced judgement [70 per Lord Templeman at 666]. He confirmed that it was up to the doctor to make use of his training, knowledge, and experience to decide what and how that information is disclosed. A doctor may therefore take the position that the patient may be confused, frightened, or misled by more detailed information which he was unable to evaluate at a time when he is suffering from stress, pain, and anxiety [70 per Lord Templeman at 664]. In his view,

the doctor impliedly contracts to provide information which is adequate to enable the patient to reach a balanced judgement, subject always to the doctor’s own obligation to say and do nothing which the doctor is satisfied will be harmful to the patient\(^6\) [70 per Lord Templeman at 666].

Lord Bridge considered the role of medical evidence and acknowledged a patient’s right to be informed about risk. He accepted that this was subject to an important qualification: that the ‘degree of disclosure of risk is best calculated to

\(^6\) Interestingly, Mr Justice Rougier in [56] repeats this passage of Lord Templeman’s and refers to this as therapeutic privilege. He goes onto define this as a situation where, ‘a doctor may be genuinely and reasonably so convinced that a particular operation is in the patients best interests that he is justified in being somewhat economical with the truth where recital of dangers are concerned’ [56 per Mr Justice Rougier].
assist a particular patient to make a rational choice whether or not to undergo a particular treatment must primarily be a matter of clinical judgement\textsuperscript{7} \cite{70 per Lord Bridge at 662}.

The topic of information disclosure in relation to risk was examined again in \textit{Pearce} \cite{63}. In a judgement described as a ‘radical departure from a reasonable doctor test’ \cite[p 109]{12}, Lord Woolf found that,

\begin{quote}
if there is significant risk which would affect the judgement of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if that information is needed so that the patient can determine for him or herself as to what course he or she should adopt \cite[p 63 per Lord Woolf at 124]{63}.
\end{quote}

Jones \cite[p 118]{49} considers the influence of the apparent combination of a prudent patient standard with a reasonable doctor standard of disclosure in \textit{Pearce}. Recognising the role of judicial scrutiny\textsuperscript{8} of what a reasonable doctor ought to disclose he notes that this ruling could effectively introduce a prudent patient standard into English law \cite[p 118]{49}. Therefore, on one view, it might appear that doctors are now under a duty to disclose all the significant risks that a reasonable patient would want to know in the circumstances. However, the impact of \textit{Pearce} seems unclear. McLean \cite[p 80]{59} cautions that even if the \textit{Bolam} test is weakened by \textit{Pearce}—as it seems to add an additional caveat to the routine acceptance of the professional standard—its actual impact is not clear. Lord Woolf introduced a qualification that,

\begin{quote}
the doctor, in determining what to tell a patient, has to take into account all the relevant considerations, which include the ability of the patient to comprehend what he has to say to him or her and the state of the patient at that particular time, both from the physical point of view and an emotional point of view \cite[p 125]{63}.
\end{quote}

His judgment would seem to offer an implicit acknowledgement that there may be particular circumstances in which it may not be appropriate to disclose certain information to the patient.

In 2004, in \textit{AB and others v Leeds Teaching Hospital NHS Trust and another} \cite{1} the subject of disclosure moved away from information regarding relative risks. In this case, the question turned on the provision of information to bereaved parents in relation to their deceased child’s post-mortem. Mr Justice Cage acknowledged that there may be circumstances in which a clinician might be justified in withholding details of a post-mortem from parents. He found the ‘blanket policy’ of withholding

\textsuperscript{7} Lord Bridge did, however, make the case for the role of judicial intervention in this process in \cite[per Lord Bridge at 663]{70}. Ruling in favour of the professional standard of information disclosure Lord Bridge entered an important caveat, ‘[a] judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonable prudent medical man would fail to make it’. However, Jones \cite[p 116]{49} identifies the difficulty has been that there are very few instances where a court has been willing to do this. One example of such an instance is \cite{56}.

\textsuperscript{8} This willingness to assess and challenge the medical profession has been analysed by Lord Woolf in \cite{79}.
of information unacceptable, even if the reason given for this was to avoid further distress to the grieving parents of a deceased child [1 per Mr Justice Cage at 327]. He qualified this, however, by emphasising the need for doctors to use their judgement, on a case-by-case basis [1 per Mr Justice Cage at 389]. Summing up this judgement he ruled that the,

evidence of the previous blanket practice, carried out by virtually all clinicians, had not appeared to have been exercised on a case-by-case basis, giving consideration to whether the information would be distressing to individual parents and families. The practice could, as such, not be justified and was negligent [1 per Mr Justice Cage at 327].

In the same year, the House of Lords considered the case of *Chester v Afshar* [18]. There was consensus that a legal duty is owed to patients to warn, in general terms, of possible serious risks in a procedure. Although obiter, Lord Steyn noted that ‘there may be wholly exceptional cases where objectively in the best interests of the patient the surgeon may be excused from giving a warning’ [18 per Lord Steyn at 16]. This recognises that there may be circumstances, albeit exceptional ones, when information might be withheld from the patient. Yet, it will be for the court to decide on the legitimacy or otherwise of the decision to withhold information.

Reviewing this body of law as a whole, there is acknowledgement that there may be circumstances, however rare, when information may be withheld from a competent patient in order to protect him from serious harm. This is justified by the obligation to act in the patient’s best interests. Further to this, the judiciary has (so far) appeared reluctant to create a legal precedent which would bind the decisions of courts or doctors in unknown, future circumstances. Thus, there continues to exist references to exceptions, albeit rare ones, within the general rules of disclosure.

**A Shift in the Standard of Information Disclosure**

There has been debate in the medico-legal literature as to the extent to which the prudent patient standard of information disclosure has superseded the professional standard. Whilst Brazier and Miola [12] agree that *Pearce* endorses the prudent patient standard and Mason and Brodie recognise, ‘for the first time, therefore, Lord Woolf introduced the reasonable patient standard of information disclosure as an acceptable part of English medical jurisprudence, and we suggest that this has been of considerable importance’ [54, p 301] others, such as Maclean, offer a less favourable assessment of its acceptance in English law [52]. At the very least, it may be argued, that there has been a shift towards further recognition of the reasonable patient standard of information disclosure. This is evidenced by the recognition of the reasonable patient standard of information disclosure in *Pearce* and that of informed consent in *Chester v Afshar*. When the standard of information

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9 However, Devany in [22] comments on *Chester v Afshar* and notes that this ‘case has not altered the duties of surgeons’ [22, p 104] and ‘the responsibilities of the courts and doctors remain the same as they ever were’ [22, p 107].
disclosure is judged using the professional standard test, decisions of information disclosure are firmly within the remit of medical expertise. Traditionally, as long as a doctor has acted in ‘accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act’ [9 per Mr Justice McNair at 587] who can provide a ‘logical analysis’ [10 per Lord Browne-Wilkinson at 243] of the reasons behind their decision then the doctor will not be found liable in negligence. In essence, the patient is entitled to be given as much information as a responsible body of medical opinion determines to be acceptable (taking into account judicial scrutiny). However, within the prudent patient test, the standard of disclosure is judged primarily by what the objective, reasonable patient would wish to know.

This distinction between the professional standard of information disclosure and that expected within the reasonable, prudent patient standard is central to the need to subject therapeutic privilege to distinct and explicit legal analysis. Within the purely professional standard, the decision to withhold information would have been considered as part of the doctor exercising their clinical skill. Whereas, the prudent patient standard focuses on the information that the patient would wish to be given. Yet, there might be circumstances when the doctor has grave concerns about the impact of this information. As a result, there needs to be some legal mechanism to determine whether withholding the information is lawful. Jackson [45] identifies that in jurisdictions which have adopted the ‘prudent patient’ test, this test has been subject to an exception, known as therapeutic privilege. She describes this exception as a suspension of the doctor’s duty to provide the patient with material information, if in the doctor’s judgement it would be likely to cause this patient harm, such as severe distress and anxiety [45, p 281]. Moreover, McLean and Mason also recognise that even the prudent patient standard allows for non-disclosure of certain information based on therapeutic privilege [58, p 50].

This raises questions as to whether the concept of therapeutic privilege is required in law. Lord Scarman believed this was the case. In Sidaway he identified that the need for therapeutic privilege within a prudent patient test stems from the fact that the prudent patient is not a real person, and certainly not the patient himself. Thus, Lord Scarman considered the existence of a need that, ‘the doctor should have the opportunity of proving that he reasonably believed that disclosure of risk would be damaging to his patient or contrary to his best interest’ [70 per Lord Scarman at 654]. So, if therapeutic privilege is established, then there is no breach of the duty to inform the patient of the particular information that may cause the harm. The extent to which the development of therapeutic privilege as a result from a move towards a prudent patient standard of information disclosure is justified and how it should be regulated requires further consideration. An appropriate starting point might be provided by looking towards jurisdictions which already operate a prudent patient standard of information disclosure.

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10 For a discussion of the criticisms of this test (along with the criticisms of the professional standard of information disclosure) see [45, p 280].
International Jurisdictions

In 1972, the classic formulation of the reasonable, prudent, patient standard of information disclosure was provided in the American case of *Canterbury v Spence* [15]. The court recognised that, ‘patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder treatment, or perhaps even pose psychological damage to the patient’ [15 per Mr Justice Robinson at 48]. Conditions were placed on the use of this privilege to keep information from the patient. Sound medical judgement is required in order to assess that the communication of the risk would present a threat to the patient’s well-being. Furthermore, it was emphasised that, ‘the privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs’ [15 per Mr Justice Robinson at 49]. The burden of proof for the appropriate use of this privilege rests upon the doctor. This stems from the patient’s *prima facie* right to be informed and because it is usually the doctor who can provide evidence to support the use of this privilege.

This judgement reveals the relationship between the archetypal notion of the reasonable prudent patient standard of information disclosure and the need for an exception based upon this formulation. Accordingly, when determining what the objective reasonable patient would wish to know, in particular circumstances, the doctor has the opportunity to invoke therapeutic privilege. This is based on the belief by the doctor that if the particular information is disclosed to the patient it will cause serious harm. However, one of the difficulties is that the precise formulation of therapeutic privilege varies amongst jurisdictions. Faden et al. [28] discuss the various formulations of the concept. Framing it broadly, a doctor would be permitted to withhold information if disclosure would result in any deterioration, however minor in the physical, psychological or emotional condition of the patient. Taking a narrower view of the concept, which Faden et al. associate with the view taken in *Canterbury*, would mean the doctor being permitted to withhold information only in circumstances when the patient’s knowledge of that information would have ‘serious health related consequences- for example, by jeopardising the success of treatment or harming the patient psychologically by critically impairing relevant decision-making processes’ [28, p 37]. They also identify a further, even narrower definition in which therapeutic privilege can be invoked if, ‘the physician reasonably believes disclosure would render the patient incompetent to consent to or refuse treatment, that is, render the decision non-autonomous’ [28, p 37].

Another case which the expounded the reasonable prudent patient standard of information disclosure was *Reibl v Hughes* [66]. In this case the Supreme Court of Canada rejected handing ‘over to the medical profession the entire question of the duty of disclosure’ [66 per Chief Justice of Canada at 882]. The court preferred the objective standard of information disclosure. Within this ruling there was a recognition that,

it may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment
and the doctor may, in such a case, be justified in withholding or generalizing
information as to which he would otherwise be required to be more specific
[66] per Chief Justice of Canada at 895.

So, within the Canadian approach to the reasonable prudent patient standard there
is an acknowledgement of an exception to information disclosure.

The High Court of Australia firmly rejected the application of the professional
standard of disclosure based on the Bolam test to cases in relation to risk disclosure
in Rogers v Whitaker [68]. Here, the standard of information disclosure and within
this the duty to warn the patient of the risks inherent in the proposed treatment was
articulated. In a joint ruling a risk was said to be material if it,

is one to which a reasonable person, in the position of the plaintiff, would be
likely to attach significance, or one which the medical practitioner is or should
be reasonably aware that the particular patient, if warned of the risk, would
probably find significant [68 at 148].

Several commentators have provided analysis of the rejection of the Bolam test in
this context and the implications of this judgement [16, 61, 74].11 The emphasis was
placed on the patient’s right to make a meaningful choice which becomes,
‘meaningless unless it is made on the basis of relevant information and advice’ [68].
The court recognised that there may be exceptional cases in which a particular
patient may be harmed by the disclosure of information. The doctor’s duty to
disclose was subject to therapeutic privilege. Thus, if there is, ‘particular danger that
the provision of all relevant information will harm an unusually nervous, disturbed
or volatile patient’ [68] the doctor will not fall below the appropriate standard of
care if he withholds this information. Again, the concept of therapeutic privilege,
albeit with limitations on its scope, is recognised within a jurisdiction which has
firmly rejected the professional standard of information disclosure in favour of a
standard which incorporates the reasonable, prudent patient standard.

The Need for Clarity

It is acknowledged by both the medical profession and the judiciary that there are
circumstances—which may be few and far between—when information may be
withheld from a patient to prevent ‘serious harm’. In the case of the professional standard
of information disclosure, it is clearly the profession itself which sets the standard for
disclosure. As the standard of disclosure moves from a professional standard to one
measured by reference to the prudent patient, this ‘privilege’ afforded to doctors needs to
be articulated further. This is because within the professional standard of information
disclosure there is an allowance for the clinical judgement of the doctor. As such,
although he would have to justify withholding information that would usually be
disclosed, this could be done within the remit of his professional judgement, a separate
privilege would not be required. However, the perspective has altered under a standard of

11 The High Court of Australia took the opportunity to demonstrate its commitment to the standard of
information disclosure established in Rogers v Whitaker [68] in 2001 in Rosenberg v Percival [69].
disclosure that is judged by reference to the prudent patient. Therefore, a privilege is required in order for the doctor to withhold information that would usually be disclosed to the patient. However, given the controversial nature of therapeutic privilege and how its use might impact on patient autonomy further consideration is required on the limits of such a privilege.

One approach might be a more formal articulation of ‘therapeutic privilege’ in English law. However, as Tickner [74, p 115] recognises the doctor’s therapeutic privilege would need to be carefully defined. She argues that ‘unless it is limited to situations in which the patient has an exceptional medical problem taking him outside the position of an ordinary patient nervous about his health and treatment, the privilege could too easily be utilised to evade the court’s scrutiny’ [74, p 115]. Other commentators take a different view arguing that therapeutic privilege is already part of English case law. Jones believes that ‘under English law the notion of therapeutic privilege is not part of a defence to a claim for non-disclosure, it is incorporated within the duty of disclosure itself, applying Sidaway’ [49, p 113]. He cautions that ‘a clear danger that an ‘exception’ to disclosure on the basis of the potential for inducing anxiety in a patient could be used to undermine the patient’s right to exercise a choice about whether to accept treatment’ [49, p 113]. Maclean [51, p 404] acknowledges that therapeutic privilege is as applicable under the professional standard as it is under a standard of disclosure compatible with a doctrine of informed consent. Discussing this point in his book, ‘Autonomy, Informed consent and the Law’, Maclean reaffirms this point and underscores that the professional standard of information disclosure can be used to assess the validity of withholding information in English law [51, p 183]. This opinion appears to be based on the arguments contained in Lord Templeman’s judgement in Sidaway [70]. Certainly, there is acknowledgement within Sidaway and subsequent cases [1, 18, 63] of exceptional circumstances when information might be withheld from patients to prevent serious harm—which is consistent with acting in their best interests. Despite this general agreement of circumstances when information might be lawfully withheld from patients, there is no explicit consensus on whether therapeutic privilege exists in English case law and a lack of clarity on its limits. Indeed, Berg et al. [7, p 80] caution in their discussion of therapeutic privilege in relation to informed consent that ‘if the scope of therapeutic privilege is not severely circumscribed, it contains the potential to swallow the general obligation of disclosure’. It seems though that given the emphasis placed on patient autonomy in subsequent cases such as Chester v Afshar [18] the decision on the validity to withhold information has been somewhat wrestled out of the hands of the medical profession. It is for the court to decide on the legitimacy to withhold information, as Lord Steyn declared, ‘in modern law, paternalism no longer rules’ [18 per Lord Steyn at 16]. Despite this, there is the view that since Sidaway therapeutic privilege has continued to find favour with the judiciary [76, p 98].

Ambiguity of Therapeutic Privilege

There appears to be at least three areas of ambiguity within the legal concept of therapeutic privilege. Firstly, there are difficulties in defining a future ‘serious harm’. Secondly, there is ambiguity as to whether therapeutic privilege extends to
the rest of the health care team and, in particular, to nurses. Thirdly, clarification is required in relation to any extension of therapeutic privilege to withholding information in areas other than risk disclosure, such as diagnosis or prognosis.

Defining a Future ‘Serious Harm’

As has been discussed, in order for therapeutic privilege to be valid, information that would usually be given to a competent patient is withheld in order to protect the patient from serious harm. The very nature of the requirement of therapeutic privilege to prevent a serious harm to the patient has several difficulties. Predicting the future and what might be a possible reaction by the patient to an element of information is hazardous. The doctor would have to rely on his training, knowledge and experience to make a professional judgement on that particular patient’s circumstances. Although these elements are useful in making any decisions they are not infallible, particularly when the decision is in relation to another person’s reactions which might be based on a different value system.

The courts have attempted to limit the use of therapeutic privilege by ring-fencing the concept with caveats such as ‘wholly exceptional’, ‘serious threat’, and ‘best interests’ when describing those rare cases when it would be relevant. These terms remain, perhaps intentionally, subjective and difficult to define. The doctor must show that the decision is in the best interests of the patient and meets the criteria considered. Indeed, the concept of harm is multifaceted. There are different types of harm to consider: psychological, physical, spiritual and emotional. The doctor would have to demonstrate clearly that, based on his assessment, the consequences for the patient would have been a significant enough harm that invoking therapeutic privilege was appropriate. In addition to the potential difficulties quantifying the extent of the potential harm that would be needed to qualify for therapeutic privilege the need for the decision to be specific in relation to that particular patient is important. This is because information that might cause serious harm to one patient may not harm another patient to such an extent.

Extension to the Team

Could therapeutic privilege extend to the other members of the health care team and, in particular, to nurses? This question is relevant because of the closeness of the nurse-patient relationship. Arguably, nurses spend more time with patients than any other member of a multi-disciplinary health care team. Given the importance of effective communication, information disclosure is a key issue for nurses and becomes increasingly significant because of the autonomous and extended roles they now undertake. A further issue is that, as part of a multi-disciplinary model of care, headed by a doctor, there is the potential for disagreements relating to decisions regarding information disclosure. Nurses may find themselves in situations where they disagree about information being withheld from the patient by a doctor invoking therapeutic privilege. Arguably, it is the assigned most senior doctor who
acts as the head of the health care team. Therefore, they would have the ultimate duty to meet the standard of information disclosure required by law. However, other members of the health care team also have corresponding legal and professional obligations. These issues merit further examination as doctors and nurses are both professionally accountable for their own practice. Professionally and legally, both owe their patient a duty of care, included within this duty are obligations to meet the legal standard of disclosure. Hence, each profession has to consider their position on therapeutic privilege. Nurses are undertaking various extended roles, many have their own caseloads and the profession is becoming increasingly autonomous. As a result, it is relevant to consider how a privilege to date only considered in terms of the medical profession, translates into nursing practice.

In order to explore how therapeutic privilege may extend to those within the health care team further consideration is required as to whom may be named in litigation. Those named in a negligence action can include: the employer of the professional (e.g. the NHS Trust or hospital) under the doctrine of vicarious liability; the individual medical professional; or the provider unit directly [41]. Brazier and Cave comment that patients who bring a claim based on the alleged negligence of a nurse rarely bother to name the nurse personally as a defendant [13]. Yet, as nurses take on more extended roles and manage their own caseload, the likelihood of nurses being the focus of legal actions increases. Hartwell argues that ‘there is nothing to say that in the law this could not be transferable to nurses and other health care workers. It is only a matter of time before cases of negligence are more common amongst the other health care workers in particular nurses’ [39, p 298]. However, the extent to which this therapeutic privilege extends to the rest of the health care teams has not been expressly examined either within case law or literature. Indeed, further clarification of the nurse’s role is needed in law. Whilst this paper is focused more narrowly on how therapeutic privilege relates to nurses, this endeavour is certainly made more challenging by the relative lack of literature addressing the nurse’s position both in health care teams and in law [19].

There are problems with any assumption that a defence of therapeutic privilege afforded to a doctor automatically extends to nurses purely by reason of their membership of the health care team. This can be highlighted by reflecting on the importance of professional accountability. It is well established that the standard of care expected from a nurse or doctor towards the patient is that of a reasonably skilled and experienced practitioner who has the same expertise in that speciality, with no concessions being made for inexperience [39, p 294]. Thus, health care professionals in England and Wales are judged by their peers, notwithstanding appropriate judicial scrutiny. The onus of proof for the validity of withholding information from the patient is on the doctor. In doing so it must be demonstrated that the criteria identified earlier withstands logical analysis, with the courts being

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12 For legal authorities see [9]. For consideration of liability of junior and inexperienced hospital staff in addition to a rejection of the concept of team negligence see [77].

13 The use of the phrase ‘logical analysis’ refers Lord Browne-Wilkinson’s ruling in Bolitho [10 per Lord Browne-Wilkinson at 243]. Within this ruling his Lordship also states that ‘in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendants conduct, the defendant can properly be held liable for negligence’ [10 per Lord Browne-Wilkinson at
the final arbiter of legitimacy of this decision. However, if the nurse has cared for and interacted with the patient then the likelihood is that the nurse also has withheld information. If the patient brings an action in negligence after suffering some harm, then the doctor has the opportunity to establish this standard has been met. But the absence of any clear direction from legal or professional guidance as to whether therapeutic privilege extends to the rest of the health care team, creates legal and professional ambiguity for the nurse. Nurses are not usually automatically protected in other areas if harm comes to the patient due to carrying out the doctor’s orders. Ultimately each nurse must answer for his or her own actions [47, p 24]. An illustration of this might be if the doctor makes a prescribing error and the nurse administers this medication. In these circumstances, the nurse remains personally accountable—legally and professionally—for his or her actions.

Nurses have direct obligations to patients in terms of their legal and professional duty of care. The importance of maintaining professional accountability is emphasised within the Nursing Midwifery Council (NMC) code of professional conduct [62]. The NMC [62] states that accountability is integral to professional practice. Nurses and midwives use their professional knowledge, judgement and skills to make a decision based on evidence of best practice and the person’s best interests to justify the decisions they make. The General Medical Council [35] states that working in teams does not change a doctor’s personal accountability for his professional conduct and the care he provides. In light of these reasons I suggest that further clarification is required in order to firmly establish whether therapeutic privilege extends to the rest of the health care team, particularly nurses.

What legal and professional options are available to nurses if they disagree with the doctor’s decision to withhold information and invoke therapeutic privilege? The nurse could engage in advocacy on behalf of the patient in situations when they feel the patient should be given this information. The preferred option would be for the doctor and nurse to discuss the issue with both giving clear reasons to support their respective positions. Hopefully, this would lead to a mutual understanding and agreement between the members of the health care team. Hewitt [42] does not believe that the nurse has the legal right to countermand any instructions relating to the withholding information if therapeutic privilege is invoked. Similarly, Dimond [23, p 156] warns that challenging a decision to invoke therapeutic privilege may lead to disciplinary action against the nurse. She suggests that ultimately the nurse would have to defer to the clinical decision of the doctor. This presents a dilemma.

Footnote 13 continued
243]. He follows this with ‘(I am not here considering questions of disclosure of risk)’ [10 per Lord Browne-Wilkinson at 243]. The emphasis of this exception is relevant when considering the standard of care in relation to risk disclosure and needs to be viewed in the context of Lord Browne-Wilkinson’s entire ruling. The significance of this phrase has been considered by Brazier and Miola [12, p 108]. They conclude that, ‘Either, his Lordship was simply and correctly flagging up the fact that questions of information disclosure were simply not relevant on the facts of Bolitho, or, more probably, Lord Browne-Wilkinson considered that restraining Bolam in the context of information disclosure has already been achieved’.

14 For an illustration of the retention of individual accountability by a doctor and a pharmacist in circumstances of a prescription error see [65]. In addition there may be shared liability when several practitioners are involved in an incident that causes harm to a patient see [24].
for nurses. Professional codes [36, 62] stress the importance of team-working and communication as well as emphasising the need for effective communications with patients. The nurse, like other health care professionals, cannot rely on the defence, ‘I was only carrying out orders’ and would have to demonstrate that he or she acted in accordance with a responsible and logically defensible body of opinion based on acceptable practice from any qualified nurse. This, of course is the same situation for the doctor, equally they would have to justify their decision. However, the fact remains that there is no legal and professional guidance discussing therapeutic privilege in relation to the nurse and the potential issues this could create within the health care team.

**Extension to Areas Other Than Risk Disclosure**

Could the withholding of information ever be lawfully extended to situations other than of risk disclosure? In English law, exceptions to information disclosure have usually been focussed on cases which involved the non-disclosure of risks within the consent process. The justification given for withholding information from a competent patient is that there has been a reasonable assessment that this information could cause the patient serious harm. Assuming the harm of disclosure would be primarily psychological, how far could the defence of therapeutic privilege be justified in terms of withholding other information from a patient? Take the example of a diagnosis of terminal illness. Johnston and Holt [48, p 148] argue that it would be untenable to apply therapeutic privilege to withholding diagnosis information and that it would be unlikely to be applied successfully in this jurisdiction. This is because, they argue, that informing a patient of a diagnosis is not part of the process of obtaining consent to a procedure, but rather stands alone and is fundamental to any further choices a patient may make. As I understand this view, Johnston and Holt seem to be making the point that informing a patient of a diagnosis is a necessary precursor to any gaining of consent. Thus, a ‘lack of information of the diagnosis precludes an informed choice by the patient and therefore information should never be withheld’ [48, p 148]. This view raises the issue of how far information can be separated into its component parts. Others, however, disagree that information concerning diagnosis may in some cases cause such harm that it may be legally and ethically justified to withhold. Cote [20] discusses the use of therapeutic privilege in relation to disclosure of intersexuality to children. She raises the issue that it is ‘not directly addressed in the literature or case law whether or not diagnosis (as opposed to risks of a procedure) can be withheld from a patient because it is feared that its disclosure will cause harm’ [20, p 206]. Dimond discusses therapeutic privilege not only in the context of risk disclosure but suggests that informing the patient that they are terminally ill may well come under this heading [23, p 156]. She explains that if, in the opinion of the doctor, it would be harmful to tell a patient such disturbing news, then the doctor can withhold such information for the reason that he is acting in the patient’s best interest.

Some of these issues were highlighted in the case of *Arato v Avedon* [2]. Here, the case which ultimately came before the Supreme Court of California, focussed on
whether the law should require physicians to disclose statistics on life expectancy to their patients in cases of illness that is likely to be terminal. In this case the doctors justified their decision to withhold information regarding his statistical prognosis on disparate grounds. These included that Mr Arato had shown great anxiety about his cancer, that it was ‘medically inappropriate’ to give this specific information, that it might deprive the patient of hope, that the patient had never specifically asked for this information and that there was a level of uncertainty about the predictive value of such statistics for an individual patient. On her husband’s death Mrs Arato brought a case against the physicians arguing that the statistical information should have been disclosed. Ultimately, the Supreme Court found in favour of the physicians affirming the trial judge’s verdict. They argued that it was ‘unwise to require as a matter of law that a particular species of information be disclosed’ [2 per Mr Justice Arabian at 1a]. However, they emphasised that in declining to endorse the mandatory disclosure of life expectancy probabilities, they did not mean to signal a retreat from the patient- based standard of disclosure’ [2 per Mr Justice Arabian at 1b]. Although this case was heard in an American jurisdiction it highlights some of the key tensions between the doctor, acting in what they perceive is in the patients best interests, and the level of information disclosure that is appropriate within the clinical context, particularly in relation to terminal diagnosis information.

This exploration does not represent an argument for extending therapeutic privilege into the arena of diagnosis and prognosis information, and should not be taken as such. It aims to highlight the ambiguity in this area. Given the strong ethical arguments in support of full disclosure and its particular importance in the end of life context further consideration and guidance is required on the validity of the use of therapeutic privilege to withhold diagnosis or prognosis information.

**Professional Guidance**

The guidance produced by the GMC [35] and the Department of Health (DH) [21] does not refer explicitly to a doctrine of therapeutic privilege. Yet, there is an acknowledgment of situations when it would be justified to withhold information from patients. The DH acknowledges that there may be rare occasions when the health care professional believes that disclosure of information will cause the patient ‘serious harm’. In these circumstances such decisions should be discussed with the team caring for the patient and the reasons for this view documented in the patient’s records. Importantly, it is noted that, ‘in these individual cases the courts may accept such a justification but would examine it with great care’ [21, p 13]. The guidance cautions that, ‘the mere fact that the patient might become upset by hearing the information, or might refuse treatment, is not sufficient to act as a justification’ [21, p 13].

Within ‘Consent: patients and doctors making decisions’, the GMC provides detailed guidance for doctors when making decisions in line with good medical practice about patient care [35]. The GMC emphasises the importance of the information exchange between doctors and patients—emphasising the need for the
relationship to be based on openness, trust and good communications. Despite this, the decision in relation to how much information is shared with patients will vary, depending on the patient’s individual circumstances. The doctor should adapt their approach to discussions with patients according to: the patient’s needs, wishes and priorities; their level of knowledge about and understanding of their condition, prognosis and the treatment options; the nature of their condition; the complexity of the treatment; and the nature and level of risk associated with investigation or treatment [35]. The guidance identifies the information that the doctor must give to patients. This includes information patients need, or want, in relation to: their diagnosis and prognosis; any uncertainties about either of these including options for further investigations; options for treating or managing the conditions, including the option not to treat; the purpose of any proposed investigation or treatment and what it will involved; and the potential benefits, risks and burdens, and the likelihood of success, for each option [35].

The GMC identifies certain justifications for withholding information from patients. Primarily, these arise when patients express the desire not to be given information about their condition or treatment. A further exception to the obligation to inform patients is described. This occurs in situations when giving the information would cause the patient ‘serious harm’. In this context ‘serious harm’ is defined as more than just the possibility of the patient becoming upset or deciding to refuse treatment [35].

An analysis of the guidance from the DH and the GMC raises two interrelated questions. Firstly, what is the standard of information disclosure required by the professional guidance? Secondly, is this standard consistent with that required by law? On one interpretation, it seems that the GMC requires the doctor to adhere to a standard of information disclosure consistent with the subjective particular patient standard. This is evidenced by GMC’s direction that doctors should focus on a patient’s individual situation, emphasising the importance of finding out about their individual needs and priorities. Yet the legal standard of information disclosure has traditionally been judged with reference to the medical professional standard notwithstanding the more recent acknowledgement of the prudent patient standard. Indeed, the DH recognises that ‘the standards expected of health care professionals

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15 This guidance has a very particular use of the terms ‘should’ and ‘must’. ‘You must’ is used as an overriding duty or principle. ‘You should’ is used when providing an explanation of how to meet the overriding duty. ‘You should’ is also used where a duty or principle will not apply in all situations or circumstances, or where there are factors outside ones control that effect whether or how to comply with the guidance’ [35, p 1].

16 See endnote 15.

17 The subjective particular patient standard of information disclosure has been criticised. Mason and Brodie argue that dependence on the particular patient standard ‘opens the door to hindsight to such an extent that its use becomes unreasonable’ [54, pp 298–9]. Maclean [52, p 394] comments that ‘the courts have always rejected a subjective standard’. However, despite identifying that a subjective test would be almost impossible to enforce, Jackson [45, p 282] acknowledges that it should not be totally dismissed as an impractical moral ideal as it is valuable for the doctor to attempt to discover the individual patient’s subjective priorities by means of inquiry. Heywood [43, p4] considers the position of the individual patient arguing that there, ‘must be at least some room to consider the position of the individual patient in relation to risk disclosure’.
by their regulatory bodies may at times be higher than the minimum required by law’ [21, p 8] and that ‘where the standards required by professional bodies are rising, it is likely that the legal standards will rise accordingly’ [21, p 8]. Nonetheless, it has been recognised that the extent to which professional guidance can determine what constitutes legally valid consent is questionable [44, p 183]. This is due in part to the standard of information disclosure being above what the law requires and a lack of obligation on the courts to follow the standards. As professional and legal benchmarks shift, they are likely to do so in an unsynchronised fashion. Should inconsistencies result, the need to minimise any variation becomes a priority. It has been argued that the law is not well known and probably even less well understood by the medical profession [49, p 106]. Empirical studies seem to suggest that whilst medical practitioners may be aware of such guidance regarding consent there is a lack of awareness of their substantive content [44]. Given the evidence of this lack of knowledge, differences between legal and professional standards may result in further ambiguity.

Professional Guidance and the Law

A full analysis of the interplay of professional guidance and the law is beyond the scope of this paper, nonetheless there are key issues within this dialogue it is necessary to address. These issues are relevant to a discussion of therapeutic privilege because of the importance of having a consistent starting point, transparent to the medical profession (and to patients), of the standards of information disclosure expected both professionally and legally. It is only by establishing the expected standard of information disclosure that one can start to consider any exceptions within the context of these disclosure norms. This section considers the relationship between professional guidance and the law in order to lay the groundwork for considering the professional and legal implications of therapeutic privilege. This provides further context for the argument that greater clarity is required on the validity of therapeutic privilege in English law.

There is clearly a role for the law in facilitating quality in health care [57]. Although the place of the law in developing a framework for the doctor-patient relationship should be approached with some caution [49, p 133] it can play a symbolic and galvanising role. Referring to this point, Lord Walker’s ruling in Chester v Afshar acknowledged the value of the iterative process between case law and professional guidance which might lead to the creation of a more substantive ‘right’ to truly informed consent for patients [18 per Lord Walker at 58]. Indeed, McLean [59, p 95] recognises that doctors may be more influenced by what their professional bodies say rather than what emerges from the courts. This issue is not new, 10 years ago, Brazier and Miola [12], commented on the impact of medical professional guidance on judges when evaluating information disclosure practices. They argued the influence of professional guidance was that it encouraged judges to take a more pro-patient stance emphasising the patient’s right to make informed decisions about their care. More recently, Miola [61] argued that the courts might use the guidance from the GMC in ‘Consent; patients and doctors making decisions together’ as the legal standard within information disclosure. Although this needs judicial approval, he maintained that it would not be unreasonable to expect the
law to hold doctors to these standards. The conclusion being that, by using Bolam to acknowledge professional guidelines as the gold standard that the reasonable doctor should follow, in the short term at least, patients’ autonomy would be supported. The ‘hostage to fortune’ that this may produce is the law’s dependence on the continued excellence of the guidance. Maclean\(^{18}\) comments on the professional guidance on consent and recognises that it places greater demands on the doctor. He continues to point out that ‘if common practice develops to reflect those demands, then—by default—English law may well end up requiring the same standard of disclosure as the doctrine [of informed consent] but this standard is built on shifting sands’ [52, p 412]. Commenting on the relationship between professional guidance and the law Miola [60, p 85] concludes that as the law moves closer to a prudent patient test and greater respect for patient autonomy it is important that this relationship does not stand still. He accepts that comprehensive and authoritative guidance from the professional sector is more demanding than the law and, as such, it can represent a gold standard to the minimum provided by the law. This is emphasised by the concerns expressed that the 2008 GMC guidance [35] represented a shift of the professional ethical standard of information disclosure within consent downwards towards the legal standard rather than the legal standard moving upwards towards the professional ethical standard [31].\(^{19}\)

Accepting that the law, professional guidance and the medical profession seem to operate in some sort of triad of influence, it would seem prudent to ensure a level of consistency and dialogue between each. The interesting issue here, it seems, is the level of influence each of these parties has on the others. Establishing a coherence and consistency in the message given by each is vital—particularly in regards to issues of communication. This is because, by its very essence, communication involves a fourth, and arguably the most important, member of this company: the patient. Thus, analysing the relationship between these parties and the standards they provide in terms of information disclosure has profound implications for the patient and the level of communication they can expect. This potential gap between professional guidance and standards expected in law leaves a vacuum and thus a lack of clarity which needs to be addressed.

**Ethical Justifications for Disclosure of Information**

There are strong ethical justifications to support disclosure of information with patients. Any exception to this by withholding information that would usually be disclosed to patients needs to be weighed against these potential objections. Obligations of truth-telling are usually justified on the basis of the principle of

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\(^{18}\) Maclean [52, pp 411–413] is referring to the 1998 GMC guidance [34] ‘Seeking patients consent: the ethical considerations. London. GMC. But the point stands for the GMC ‘Consent: patients and doctors making decisions together’ [35].

\(^{19}\) Forvargue and Miola [32] discuss the relationship between the GMC guidance [35] and the law pertaining to the legal standard of information disclosure. They conclude that if the law requires doctors to act ‘reasonably’ in terms of information disclosure then the GMC guidance may be seen by a court as the definition of how the reasonable doctor would act. In this respect, the law would essentially be drafted by the medical profession [32, p 15].
respect for autonomy, obligations of fidelity, and the relationship of trust that is inherent in the doctor–patient relationship [78]. Health care professionals are generally respected for their honesty [33] and this covenant of trust between doctor and patient is central to the practice of medicine [6]. A lack of candour or outright deception, however well intentioned, can undermine the public’s confidence in the medical profession [21].

It has been argued that at the heart of truth-telling is the notion of autonomy [3]. The decision not to tell the truth to a patient, whether about diagnosis, prognosis or the potential risks or benefits of the alternative treatment options has been described as the doctor making a unilateral decision to deny the patient the opportunity to exercise their autonomy [50]. Respecting the autonomy of patients has become a central ideal in modern-day health care. The guiding principle of individual autonomy is the belief that patients should have a meaningful role in decisions about their own care and treatment. In this sense, autonomy relates to having an authentic role in decision-making. In a wider context, the opportunity and ability to exercise choice allows individuals to have control over their own destiny. As such, autonomy is seen as something to aspire to and strive towards, the idea being to maximise autonomous decision-making as far as possible. Autonomy, on this view, acknowledges that rather than decisions having to be fully autonomous they need to be as autonomous as practicable. As autonomy is about making decisions, arguably, part of this process requires that we have the relevant information on which to base that decision. There is evidence to suggest that many patients want detailed diagnostic and prognostic information [30, 33, 38, 53]. In addition to this, far from increasing anxiety and distress, communicating information effectively has been said to reduce patient’s anxiety levels [29]. The corollary of this is that a lack of information has been linked with higher levels of worry in patients. Importantly, the role of hope in this communication process is seen as significant in patient welfare enabling the patient to focus on the positive, to connect to others, and to continue to engage with life [25, p 138].

Further risks of non-disclosure of information include the possibility that patients who remain uninformed about their condition may fail to seek medical attention and treatment when they should [40]. Patients may make decisions affecting their lives that they would not have done had they been in possession of this information. This can result in a patients being prevented from making informed decisions about their care. In addition, withholding relevant information without patients’ knowledge or consent may have negative long-terms consequences for the medical profession particularly in terms of undermining the trust and confidence patients may place in the doctor [8]. Indeed, examinations of healthcare professionals’ perspectives regarding information disclosure in clinical practice appears to identify a presumption in favour of disclosure and an uncertainty as to the precise nature and applicability of therapeutic privilege [44, p 160].

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20 For a full discussion on notions of trust and honesty in medicine see [46].

21 For a comprehensive discussion of lying see [8] in particular Chap. 15 ‘Lies to the sick and the dying’ [8, pp 220–242].

22 However, it is acknowledged in [44] that there is uncertainty as to the extent to which the practitioners studied recognised any withholding of information as therapeutic privilege, but rather using professional judgement in tailoring information to the needs of individual patients.
A Way Forward

Whilst there are strong ethical justifications to support information disclosure, there remains the possibility of individual circumstances when disclosure could cause serious harm to patients. One way to reconcile this with the ethical arguments in favour of disclosure is to ensure that this privilege is clearly articulated and the limits of its application explicitly considered. This could be done in several ways. Further articulation in law could be obtained by the judiciary considering the areas of ambiguity identified. This could be achieved within comments on legal judgements, obiter or not. One possible objection to this might result from an unwillingness to bind the judiciary and the medical profession to a course of action in future, unforeseen circumstances. This is a reasonable concern. However, providing further clarification on the status of therapeutic privilege in English law and establishing its boundaries is timely given the emphasis on disclosure of information and its importance for patients. Another avenue of providing further clarification could be developing a joint statement employing expertise from legal and professional arenas. A constructive dialogue with professional groups, legal representatives and patient groups to discuss the existence of such a privilege in contemporary health care would seem a positive first step. Within this discourse an exploration of the ethical justifications for and against such a notion, along with its consistency with principles in modern health care is needed. This is just the area that The American Medical Association Council has attempted to address in their report on ethical and judicial affairs on withholding information from patients. Here, the validity of therapeutic privilege was explicitly considered with the clear recommendation that withholding information from patients without their knowledge or consent is ethically unacceptable. A similar exposition of therapeutic privilege within the English context would be useful in order to establish the ethical, professional and legal position. Within this it is also necessary to develop clear guidance on whether this concept extends to areas other than risk disclosure—such as diagnosis, prognosis, and the extent to which therapeutic privilege extends to other professionals in the health care team. In order to frame this discussion in clinical practice scenarios could be used to illustrate and explore the potential tensions within information disclosure and test the validity of therapeutic privilege.

23 The abolition of therapeutic privilege in relation to informed consent is discussed in [7]. Berg et al. [7, p 85] conclude that ‘if there is any room at all for therapeutic privilege, it must be framed narrowly in terms of interference with patients decision-making capabilities and applied only in extreme cases’.

24 Although there is recognition within the recommendations that there might be circumstances when a delayed disclosure could be considered. For further comment on this report see [64]. Others have called for even more specific guidance, for example defining the harm or ‘medical contraindication’ which would justify withholding treatment see [71].

25 For examples of scenarios which illustrate additional information disclosure dilemmas and exploration of how to practically apply the American Medical Association guidelines see [71].
Conclusion

Providing patients with information is seen as a fundamental part of respecting their autonomy. The law reflects this principle through the concept of consent and the importance it places on respect for patient autonomy. Despite this, there is an acknowledgement within case law that there may be circumstances when the doctor may withhold information to prevent serious harm to the patient. This has been discussed primarily in relation to disclosure of risks. The exception has been viewed as part of the legal benchmark based on the professional standard of information disclosure. As the standard of information disclosure moves towards one based on the reasonable prudent patient standard, the need for a formal articulation of a doctrine of therapeutic privilege intensifies. In this context, doctors require the privilege to withhold information, which would usually be disclosed, on the grounds of preventing serious harm to their patients. However, there are strong ethical arguments in favour of disclosure of information to patients. In light of these, further clarification is required on the grounds on which this exception exists, the information that could lawfully be withheld and how this exception extends to rest of the health care team, particularly nurses.

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How should a nurse approach truth-telling? A virtue ethics perspective

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Abstract
Truth-telling is a key issue within the nurse–patient relationship. Nurses make decisions on a daily basis regarding what information to tell patients. This paper analyses truth-telling within an end of life scenario. Virtue ethics provides a useful philosophical approach for exploring decisions on information disclosure in more detail. Virtue ethics allows appropriate examination of the moral character of the nurse involved, their intention, ability to use wisdom and judgement when making decisions and the virtue of truth-telling. It is appropriate to discuss nursing as a ‘practice’ in relation to virtue ethics. This is achieved through consideration of the implications of arguments made by Alasdair MacIntyre who believes that qualities such as honesty, courage and justice are virtues because they enable us to achieve the internal goods of practices.

Keywords: truth-telling, virtue ethics, nursing, nurse–patient relationship, professional practice.

What this paper adds to what is already known on this topic: This paper adds to the body of knowledge on this topic as it applies the philosophical theory of virtue ethics to a clinical scenario in order to analyse the decision-making process of the nurse involved from this virtue ethics perspective.

Introduction
Truth-telling has been recognized as a key issue in bioethics and has been considered from philosophical, professional and ethical perspectives (Bok, 1999; Jackson, 2001; Fallowfield et al., 2002; Costello, 2004; Tuckett, 2004). This paper will focus on truth-telling within the dynamics of the connection between nurse and patient. The therapeutic nature of this nurse–patient relationship is a central concept in nursing. Within this bond issues such as truth-telling, compassion and communication are important. Nurses are often involved in discussions with patients that require decisions to be made regarding information disclosure. However, these discussions can be complex. Decisions will be made in a number of ways, by reference to legal and professional frameworks, by experience or intuition or by guidance from others. These mechanisms are useful to aid decision making in relation to truth-telling. However, there also needs to be further
consideration of the philosophical framework used and the moral reasoning required to make such judgements.

The complexities surrounding truth-telling can best be illustrated in the context of a real-life scenario: a critically ill patient is in the last hours of life. The patient asks the nurse looking after them, ‘am I dying?’ Many nurses respond intuitively to this situation depending on their professional experience in dealing with similar situations. This scenario raises a number of questions in terms of the nurse’s response, does she: Opt for full disclosure and explain sensitively the inevitable consequences of the patient’s condition? Avoid the issue and make vaguely comforting statements? Ignore the patient’s questions, or reflect them back to the patient? Lie – by omission or commission – and deny the fact that the patient is dying and/or focus on the imagined prospects for recovery? I will advocate the use of virtue ethics as a philosophical approach to inform issues of information disclosure. This is because virtue ethics allows an analysis of the moral character of the nurse involved, their intention, ability to reason morally and the virtue of truth-telling.

Virtue ethics

Virtue ethics focuses on the moral character of the agent, how the agent exercises the virtues and how they live their life. In considering how the nurse should act in this situation it is important to identify what the appropriate virtues are and consider how the virtues contribute to the nurse making morally good decisions.

Many influential contemporary philosophers have discussed virtue ethics (Anscombe, 1997; Slote, 1997; Hursthouse, 1999; Foot, 2002; Adams, 2006; MacIntyre, 2007). There is a range of emphases in and interpretation of virtue ethics within this body of work. It will be a neo-Aristotelian perspective along with modern philosophers’ interpretations of strong virtue ethics (Hursthouse, 1999; MacIntyre, 2007) that will form the perspective of virtue ethics for this paper. However, as Aristotle is arguably one of the founding influences of virtue ethics, appropriate reference to Aristotle will also be made within the paper. A strong view of virtue ethics embodies the belief that ‘virtue ethics and the virtues are capable of doing all the work of ethics’ (Armstrong, 2006, p. 118). Strong virtue ethics is a single theory which needs no supplementation from other ethical frameworks.

The virtues

First, I will define what is meant by virtues and discuss the appropriate virtues that a virtuous person should possess and exercise. There has been a great deal of discussion by philosophers writing on virtue ethics in the attempt to define ‘virtues’. For the purposes of this paper a virtue is ‘a character trait, habitually performed, which disposes one to act, think and feel in morally excellent ways’ (Armstrong, 2006, p. 115). In relation to the scenario of the questioning dying person it is appropriate to consider the specific character traits which would help the nurse to act in a morally excellent way. It is also appropriate to consider what is meant by ‘morally excellent’. There has been considerable debate about which virtues should be included in any list of essential virtues as well as whether or not the virtues exist as a hierarchy. Aristotle produced a list of virtues and vices (Aristotle, 1953). Truthfulness is included in this list as the mean between the excess of boastfulness and the deficiency of understatement. Aristotle states that ‘falsehood is in itself bad and reprehensible, while the truth is a fine and praiseworthy thing’ (Aristotle, 1953, p. 105). He argues that the virtuous will speak the truth when nothing depends on it and will speak it all the more when something does depend on it. Falsehood is viewed as something dishonourable. As the mean of truthfulness sits on the continuum of boastfulness and irony or self-deprecation, it can be argued that this virtue has more to do with being ostentatious and boastful about oneself or one’s achievements and less to do with truth-telling within an end of life context. Nevertheless, it does show the emphasis Aristotle places on truthfulness being an appropriate virtue. As Aristotle was writing about virtues two and a half millennia ago in ancient Greece, it is also important to consider some more modern interpretations. Other philosophers, writing more recently, have also identified the virtue of honesty in their work (Hursthouse,
According to these commentators the virtue of honesty seems essential for the virtuous person. In our scenario the virtuous nurse would be an honest nurse and one that would have developed the ability to see the median without undue deliberation and thus be in a position to act in the right way, and to the right degree, in relation to honesty. In this sense moral action becomes a match between situation and principle. This is a situation that calls for truth-telling. This much seems clear, but it is worth analysing further, the extent to which virtue ethics does provide guidance on how to act, feel and think.

**Criticisms of virtue ethics**

Various philosophers have identified and discussed the perceived shortcomings within virtue ethics theory (Veatch, 1988; Louden, 1997). Indeed, one of the criticisms of virtue ethics is that it does not provide a clear set of rules or guidance for actions in different contexts. Critics of virtue ethics argue that it is not enough just to say that the virtuous person should act virtuously. The inclusion of different virtues with no established hierarchy of virtues leads opponents to argue that it is not helpful in complex situations where there may be competing virtues. Hursthouse (1999, p. 36) discusses this point and argues that virtue ethics can provide rules for action stating that each virtue generates a prescription and each vice a prohibition. These are referred to as v-rules. If this is applied to the scenario, then the virtue of honesty would require the nurse to do that which is honest and to avoid that which is dishonest. This is because honesty is a virtue and dishonesty a vice. However, is it as simple as this? Within this situation there may be other competing virtues such as compassion. Therefore, it is important to be able to interpret the rules and decide how to act according to all the virtues. To do this one needs to be able to use reasoning and wisdom.

Critics of virtue ethics also argue that the central proposal in virtue ethics, that an action is right if it is what a virtuous agent would characteristically do in the circumstances, is circular in nature and a truism. They argue that this tenet only provides guidance for action if an individual is, and knows she is, a virtuous agent. Proponents of strong virtue ethics argue that having an idea of the virtues and v-rules provides a satisfactory account of what the virtuous person would do. This together with the ability to reason correctly about moral matters does indeed provide guidance for action.

**Moral reasoning and practical wisdom**

Within the given scenario there are different courses of action available for the nurse. All of these may reflect differently on the moral character and reasoning of the nurse. At this critical point it is important that the decision-making process of the nurse involved is considered. How can the nurse decide what level of information disclosure there should be in this situation? What should guide the nurse when making this decision? The nurse certainly should act in accordance with appropriate legal and professional frameworks. However, often such frameworks can only give general guidance and blanket statements that do not allow for the complexities of these decisions. Therefore, it is vital that in addition to these frameworks the nurse should have the ability to use reason and moral judgement within any decision-making process. This is in order to be able to make morally good decisions in relation to patients in different situations. The importance of practical wisdom (phronesis) is one of the areas emphasized in Aristotelian virtue ethics. Phronesis is an intellectual virtue without which none of the virtues of character can be exercised (MacIntyre, 2007). For Aristotle, the virtue lies in the mean. It is by acting at the right point, or to the right degree, and for the right motives, i.e. the mark of virtue. To make a judgement at the right point and right degree the nurse needs to possess and use moral reasoning.

However, will practical wisdom and reasoning always lead to a morally good decision or the morally right decision? This is worth examining in relation to ‘hard’ cases in the healthcare context. The emphasis on practical wisdom in virtue ethics is clear. Therefore, it is important to consider how practical wisdom can be developed. Aristotle makes the distinction between intellectual virtues, which are acquired through teaching, and the virtues of character...
obtained through habitual exercise. Moral education plays a central role in virtue ethics (Hursthouse, 1999). A full exploration of how practical wisdom can be best taught, if it can, is beyond the scope of this paper. As there are both intellectual and moral virtues it is useful to consider how teaching and habituation combine within moral education. If intellectual virtues can be taught, and by teaching I mean the way in which knowledge is imparted from one generation to the next, then we need to think about how this can be done. Moral goodness, according to Aristotle, is the result of habit. We learn from exercising the virtues, e.g. it is the way that we behave in our dealings with other people that makes us just or unjust. Aristotle explains that like activities produce like dispositions (Aristotle, 1953, p. 32). It would be useful to analyse further the combination of teaching and habituation within the context of nurse education and the nursing profession.

Hursthouse (1999) discusses resolvable, irresolvable and tragic dilemmas. These are dilemmas and moral conflicts in which there is a conflict in virtues, in our case, perhaps honesty and compassion. As I have suggested there is no identified hierarchy of virtues to turn to. Therefore, it is vital to be able to use practical wisdom to decide what the virtuous person would do. In the example offered in this paper there may be reasons the nurse would withhold aspects of information in the attempt to avoid harm and distress to the patient and to try to preserve hope. In this case the virtue of compassion may be sufficiently important that the virtuous nurse used their practical wisdom to decide that it was a situation when even an honest person could withhold parts of the truth. There may also be reasons that the nurse would disclose fully the situation to the patient, believing that this is what an honest person would do. It may be that in this situation the nature of the truth is such that it outweighs other concerns. This is not to say that if the nurse decides to opt for full disclosure then she will abandon the virtue of compassion. The virtuous nurse would then deliver the information in a compassionate manner. It is also not sufficient to believe blindly that the nurse is morally good by withholding the truth in order to adhere to the virtue of compassion. Again, there needs to be wisdom used when considering the requirement to act at the right time, to the right degree, in relation to both honesty and compassion.

The nurse may deliberate over her course of action and feel unease at whichever decision she makes despite using her practical judgement and reasoning. Hursthouse (1999) describes this as the ‘moral remainder’. It is appropriate for the virtuous individual to feel emotions such as regret, guilt or remorse. These feelings come as a result of being aware of the complexities involved in moral dilemmas. Foot (2002) discusses in detail the question of whether the more virtuous person is the person who acts with ease choosing the virtuous course of action? Or whether the more virtuous person is the person who chooses the same course of action despite it being a harder decision for them? Hursthouse (1999, p. 95) also explores this distinction. She concludes that there may be other things that make it hard for an individual to act well, other than potential deficiencies in their character. It may be that the circumstances are such that even the virtuous character is ‘severely tested’. For Aristotle the virtuous person acts virtuously because they are of good character. They act in the right way and choose the right things happily. However, it may not be as easy as that. In our situation the nurse may know that the right way to act is to tell the patient honestly the full truth and be fully committed to the virtue of honesty. Despite this the nurse may feel unease in having to impart this information to the patient. To illustrate this point it is possible to imagine a situation involving the son of this patient who has already spoken to the nurse explaining the reasons why, as he sees it, his mother should not be informed of the prognosis. The son claims to know his mother best and is certain that the effects of full disclosure would be devastating to her. The nurse may have explained, as can happen in practice, that she would not initiate the conversation, but, if asked directly, she would have to respond honestly. Within this situation even when answering the patient honestly the nurse may still have feelings of guilt for going against the wishes of the son and because of the uncertainty of the consequences of the information for the patient.

For Adams (2006, p. 6) a virtuous character is not sufficient or indeed necessary to ensure right action.
He describes an example: a businessman may deal honestly only because they fear dishonesty would damage their business, rather than acting from being of virtuous character. Applying this to the end of life scenario the nurse might decide to withhold some information from the patient. This decision could have been reached for several reasons. One of these reasons could be that the nurse fears unfavourable repercussions from the patient’s son who might be angry to find that his mother had been informed of her prognosis in spite of his wishes to the contrary. Or perhaps the nurse is having a busy shift and does not have the time to discuss this issue with the patient. However, the same action of withholding information might be taken by the nurse but from different motivations. The nurse may decide acting to the right degree in terms of honesty, in this case, would mean withholding some information. This decision might have been reached after considering the situation using practical wisdom. The nurse may truly have reason to believe that full disclosure would significantly harm the patient. In both cases, the same action is taken but from different motivations. It is worth asking, if the result is the same in both cases, then do the reasons behind the action matter? This introduces the importance of motivation within virtue ethics.

Motivation

Many virtue ethicists emphasize the importance of motivation and of acting from the appropriate dispositions for right action. Motivation is important within virtue ethics because of the focus on the moral character of the individual. Foot (2002) explores what it means to say that a person has a motive for action. It seems that motivation and intention are linked. Foot argues that intention in acting means aiming at a certain thing, and the motives for this action often mean the aim in doing the action. However, an important aspect of the link between motives and intention is that motives cannot be determining forces. One cannot be said to have the intention to perform an action if one is unwilling to carry out the steps required to achieve that goal. Slote (1997) discusses the distinction between doing the right thing on the one hand and on the other of doing the right thing for the right reason. Taking an agent-based rather than agent-focussed approach, he argues that the rightness of an action depends on the actual motivation that lies behind it. Slote then attempts to rebut the claim that this makes it morally irrelevant what an actions an individual actually takes as long as the motives are good. He argues that acts are not virtuous just because they are performed by someone who possesses virtuous motivation, but the act also has to exhibit the proper motivation to count as virtuous. Hursthouse (1999) also emphasizes that it is not enough just to act in certain ways, and that to possess a virtue one must also act in those ways for certain sorts of reasons. Therefore, it is important to consider the motivation of an individual as this reflects on their moral character.

Despite the importance of motive it is not enough on its own to ensure right action. Oakley & Cocking (2001) explore whether people with virtuous characters can sometimes be led by virtuous character traits to act wrongly. They give an example of relevance to this discussion that illustrates the point. The example involves a doctor withholding a diagnosis of terminal cancer from a patient but informing the patient’s family and asking them to join in the deception. The doctor may be acting out of the virtue of benevolence or compassion. However, in this case even though the doctor is acting out of good motives, this does not seem to be enough to ensure right action. There also needs to be a practical component, in our case practical wisdom, which involves ensuring, as far as is possible, that the actions taken bring about that which virtue dictates. Oakley & Cocking (2001) question whether, in situations like this, the agent really does have the virtuous character trait which we are assuming they do. Alternatively, the individual may be lacking in another character trait which is relevant, in this situation, the character trait of honesty.

What is a morally good decision?

A further question that needs to be explored is, what is a morally good decision? It may help to consider how competing philosophical frameworks may approach this question in relation to the scenario. It is difficult to examine this question without turning to
more outcome-focussed philosophical frameworks calculating the consequences for the patient and for the nurse. The nurse may make their decision based on what they feel the consequences of withholding information or full disclosure are to the patient. This may be in terms of predicted harm or distress to the patient, or effects on hope, autonomy and their decision-making ability. However, there are difficulties with this approach which are the well-rehearsed criticisms of outcome-based philosophical frameworks. These include: the difficulties of predicting consequences both in the short and long term; and whether the nurse is able to make decisions about what is important to a patient based only on the patient’s own values. Having the rightness or wrongness of actions solely embedded in the consequences of those actions increases the level of uncertainty in decision making. This is because of the difficulty of being able to predict consequences in any absolute sense. The best that can be done is to accept that there may be a range of consequences, with some being more probable than others. Therefore, in this situation the nurse may consider a range of possible consequences for the patient, and perhaps also for herself. She would then make a decision based upon what she believes to be the best course of action as determined by those consequences. Although virtue ethics is agent-focussed rather than outcome-focussed, it is a teleological theory that cannot deny consequences.

Turning to deontological frameworks, for contrast, how should the nurse make a morally good decision? Truth-telling is supported by the best-known deontological perspective because one has a duty to tell the truth, and like every other duty this must be upheld. In Kant’s moral philosophy truth-telling fulfils the categorical imperative for universality. He says, ‘Truthfulness is a duty that must be regarded as the basis for all duties founded on contract, the laws of which would be rendered uncertain and useless even if the least exception to them were admitted’ (Kant, 1923 p. 363). According to Kant, individuals must always reveal the truth irrespective of the consequences. Applying this absolute perspective to telling patients the truth means that there would be no exception to this rule. This framework does not allow for a consideration of the specifics of a situation or of the moral character and reasoning of the individuals involved. There is a danger that adhering to moral absolutes (such as truth-telling) in all cases may do more harm than good (Begley & Blackwood, 2000). Some philosophers, including Ross (2002), discuss duties in terms of being prima facie rather than absolute. However, applying the absolute perspective to the given scenario the nurse would answer the patient giving full disclosure regarding their imminent death, and this would be without regard to the consequences for this patient.

As illustrated in the application of two of the more established philosophical frameworks of consequentialism and deontology, both provide some guidance for how to act in this type of situation. However, it is possible to imagine other situations involving unknown consequences where the dynamics are so complex that an absolute rule is unhelpful. Virtue ethics provides a useful alternative because it focuses on the moral character of the individual and on their ability to use practical wisdom. This means that however complex a situation might be, a consideration of the morally good decision can be made by the individual in relation to the virtues by the use of practical wisdom.

In the situation described, the patient has asked the nurse the question, ‘Am I going to die?’ It might be that their question is prompted by an awareness of the possibility that their death may be imminent. It might be felt that to answer this question honestly is to adhere to the virtue of honesty. However, not all patients will be prompted in this way to ask this particular question leaving the nurse who is aware that the patient only has a few hours to live with a different sort of decision with which to grapple. The patient may not ask the question for different reasons. It may be that they do not wish to know the answer, it may be that they do not realize their death is imminent or it may be that the patient does not know how to ask the right sort of question. Taking this into account the question ‘is it virtuous for the nurse to wait until the patient does ask the question?’ becomes of central importance. To answer this question it is necessary to further explore the nurse’s role in such situations. In all probability the nurse will have a greater awareness and more knowledge about the clinical prognosis
than does the patient. This imbalance in knowledge between the patient and the nurse leads to some interesting questions in relation to the nurse’s role including the question: does the knowledge gained from the nurse’s professional standing impose a higher duty on the nurse to ensure that the patient is fully informed? It may be the case that the patient neither knows what or how to ask the appropriate type of question and this implies that responsibility for informing (or not informing) the patient lies with the nurse. These are issues about which the nurse should be aware when considering levels of information disclosure.

**Nursing as a practice**

In this paper the decision-making process of the nurse involved in a particular situation is being explored with the help of the virtue ethics approach. The nurse in the scenario is a person undertaking the role of nurse. As one of the central questions in virtue ethics is, ‘What sort of person should I be?’ this merits further examination in relation to the individual involved, who, in this instance, happens to be a nurse. It is worthwhile considering Alasdair MacIntyre’s thesis in *After Virtue* to try to begin to analyse these issues (MacIntyre, 2007). Within this work MacIntyre characterizes virtues in terms of practices. This is relevant in this discussion as nursing has been proposed as a particular type of MacIntyrean practice (Sellman, 2000). The core virtues identified by MacIntyre within a practice are the virtues of justice, courage and honesty.

MacIntyre, by analysing the various lists of virtues described through history, identifies the difficulty in compiling a consistent set of virtues owing to the different social, historical and cultural contexts of those writing about the virtues. MacIntyre argues that virtues need to be situated in relation to practices. He defines a practice as:

... any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence, which are appropriate to and partially definitive of that form of activity. (MacIntyre, 2007, p. 187)

MacIntyre argues that practices have internal goods attached to them, i.e. goods that can only be achieved by performing the practice and have value to the individual as such. This is differentiated from an activity that primarily has external goods attached to it. External goods mean that there are alternative ways of obtaining these goods other than by engaging with the practice, e.g. money or status. Sellman (2000) discusses nursing as a professional practice. He identifies that within the practice of nursing there are particular internal rewards such as the positive feeling associated with helping others and the long-term progression of engaging with the practice of nursing. The presence of these internal goods does not preclude the fact that there may also be external goods related to the practice, e.g. a wage. Sellman (2000) differentiates nursing as a professional practice as it requires commitment and continuing engagement to the care of a given individual, or of given individuals, and to the tradition and enhancement of the practice of nursing.

MacIntyre argues that virtues not only need to be situated in relation to practices, but also in relation to the good life. This ‘quest’ for the good to increase self-knowledge and knowledge of the good takes place against the narrative of our lives. The narrative unity of an individual’s life is important to MacIntyre. He argues that someone who genuinely possesses a virtue is expected to be able to exercise it in very different types of situations. Therefore, the individual should not just possess a virtue in relation to any particular role they play in society but needs to have unity of character and the life narrative within which the character exists (MacIntyre, 2007). This link from the practice of nursing to the conception of self in morality suggests a need to think about how the virtues of the individual engaged with the practice of nursing relate to the virtues that same individual exercises when not in the work place practising nursing. If these virtues are the same, then it is important to think about which virtues are important both for the practice of nursing and for the individual in their life.

This brings about a third stage within which virtues need to be situated, that of tradition. For MacIntyre tradition is important as practices have a past, a present and a future. The fact that practices have histories influences the understanding of what that...
practice is. An individual’s ‘quest’ for their good is conducted within the context defined by those traditions of which the individual’s life is part. It is the virtues that sustain and strengthen traditions. It is important, therefore, that the virtues are consistent with the moral traditions of that practice and within the narrative unity of an individual’s life.

Through his thesis MacIntyre further develops what is meant by virtues in an attempt to overcome the difficulties associated with defining the nature of virtues. Virtues can be understood as those, . . . dispositions which will not only sustain practices and enable us to achieve the goods internal to practices, but which will also sustain us in the relevant kind of quest for the good . . . and will furnish us with increasing self knowledge and increasing knowledge of the good. (MacIntyre, 2007, p. 219)

The importance of situating virtues within a practice, the quest for the good life (the narrative unity of an individual) and the tradition of that practice can be discussed in relation to nursing. As has been suggested nursing has previously been described as a particular type of MacIntyrean practice. While I cannot develop this line of thought fully here, I can, nonetheless, look at this more narrowly in relation to the scenario. If nursing is a practice, then within this the nurse should exhibit the virtues of that practice, those that MacIntyre identifies as the virtues of honesty, courage and justice. Therefore, in relation to the scenario the nurse needs to be honest, so we would think the nurse should answer the patient honestly. An individual should not just possess the virtues within the role they play as a nurse in society: there should also be a unity between this and the life narrative that the nurse inhabits. If honesty is a virtue for an individual, then it should also be a virtue for the individual when carrying out their role as a nurse. This can then be related to the moral traditions of the practice. The moral traditions of nursing have been discussed in many contexts. The UK code for nurses gives some indication of current professional and ethical standards of performance (NMC, 2008). Within this there is an emphasis on the patient’s right to accurate and truthful information. Insight into the moral traditions can also be gained by looking at both historical and contemporary writing on nursing (Nightingale, 1952; Smith & Godfrey, 2002; Miller, 2006). If the nurse is part of the traditions within the practice of nursing, their moral character will need to be consistent with those traditions. This is important when considering the relationship between the moral character of the individual and the moral character of that same individual carrying out a particular role in society.

Conclusion

This paper has argued that the philosophical approach of virtue ethics is of value, not only in terms of providing guidance regarding how to be, but also how to act. These issues have been examined within the context of a clinical scenario involving disclosure of information at the end of life. The scenario was used as a mechanism to explore the role virtues might play as the nurse decides how to answer the patient’s question: ‘Am I dying?’ Many nurses would answer this question intuitively, based on their experience of these types of conversations, or by reference to their own moral compass. However, it is important to be able to reflect more deeply on how decisions are made and the moral character of the individual involved. Intention has been emphasized as an important component of virtue theory. As Aristotelian virtue ethics is a teleological theory, the focus on intention and analysis of the appropriate motivating goals, aids in the analysis of moral character. Applying MacIntyre’s work to the scenario enabled further discussion of how virtues can be thought of in terms of practices, the narrative unity of an individual’s life and the moral traditions of that practice.

References