Truth Telling to Patients with a Terminal Diagnosis

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Introduction

This paper deals with the dispute, within Orthodox Jewish law and practice (halacha), over the issue of truthful disclosure to patients concerning their terminal diagnoses/prognoses. The preponderance of opinion, as reflected in the halachic literature, which we herein review, is heavily weighted in opposition to truthful disclosure. It is reasoned by these sources that survivability/longevity is dependent upon hope/high-morale, which is undermined by knowledge of the truth. While the connection between hope and survivability can be reasonably demonstrated, the supposedly negative effects of truthful disclosure upon hope/morale have, on the other hand, not been adequately demonstrated and are challenged in this paper.

The intent of the halacha is to prevent any emotional harm to the patient which would have the effect of shortening his life. This paper questions the methodology usually recomended to achieve that intent. Our examination of the ethical issues, empirical evidence, and expert opinion based upon experience, brings us to the conclusion that in many cases, truthful disclosure can improve morale rather than damaging it, thereby contributing to extended longevity; and therefore, where appropriate, truthful disclosure is to be preferred over suppression of the unpleasant, as a fulfillment

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of the requirements and objsctives of the halacha.

I. Truth-Telling in Halachic Perspective

Before we approach the specific subject of truth-telling to the terminal patient, it would be useful to review the principle of truth-telling in general, from a Jewish point of view.[1]

The Bible itself commands: "Keep far away from a matter of falsehood."[2] The Talmud, in the name of Rabbi Chanina, states that "The seal of God is truth."[3] And in *Perek Chaylek*, the Talmud condemns liars as one of four classes of people who will not be admitted to the Divine Presence in the World to Come.[4]

The Mishna in *Avot* (1:18) says that the world depends upon three things: Truth (אמת), Law/Judgment (דין), and Peace (שלום). Some commentators[5] appear to explain these three things in consequentialistic terms (viz. that human society is held together by them), but we shall presently see that truth is a primary, independent value. These commentators are simply pointing up the consequences that accrue to society as *added benefits* of these values.

Another issue which can easily be brought to mind by this mishna is the question of the conflict of values. This mishna names three important values; there may be others, too, as we shall see. Are these values absolute? What happens if there is a conflict amongst them?

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1. The Talmud briefly discusses the diplomatic "white lie" in *Bava Metzia* 23b and *Ketubot* 17a. The "white lie" does not fall within the purview of this paper.
2. *Exodus* 23:7
3. חותמו של הקב"ה אמת. The statement is made in *Yoma* 69b, *Sanhedrin* 64a, *Shabbat* 55a.
4. *Sanhedrin* 103a

   ואמר ר' חסדא אמר ר' ירמיה בר אבא ארבע כיתות אין מקבלות פני שכינה . . . שקרנים . . . דכתיב דובר שקרים לא יכון לנגד עיני

   Translation: "Rav Hisda said in the name of Rabbi Yirmiya b. Abba, 'Four classes will not be received before the Divine Presence . . . liars . . . as it is written [*Psalms* 101:7], "The speaker of lies shall not tarry in My sight.' "
5. Rabbenu Ovadia mi-Bartenura, and the Meiri cited by Pinkhas Kahati, *Mishnayot M'vuarot*, (Israel: Keter Press, 1974) Vol. 8, p. 322.

According to R. Saadia Gaon,[6] the principle of truth-telling is a basic axiom not only of ethics but of knowledge itself. In his epistemology,[7] R. Saadia cites three primary sources of knowledge: (1) sense perception or direct observation; (2) "intuition of the intellect;"[8] and (3) logical inference. As his illustration of the second, he cites the notion, taken to be self-evident to the human mind, that "truthfulness is good and deceit is abhorrent." So axiomatic is this notion that it can be used as an illustration without the need for proof nor for utilitarian justification.

(For completeness, mention should be made here of R. Saadia's small, apparent concession to consequentialism in the process of rejecting it. He points out the mutual exclusion between the facts and a lie and says that the consequence of this contradiction is "grotesque" to the soul. He then goes on to give the familiar definition of utilitarianism in terms of pleasure versus pain and roundly rejects it.)[9]

The importance of truth-telling as a fundamental ethical principle in Judaism is made clear from the above. The rightfulness of truth-telling, as R. Saadia presents it, is independent of the benefit or harm of its consequences. In contemporary ethical terminology, then, we can classify truth-telling as a "deontological principle" in Judaism.

Now let us explore the question to which we alluded above, when citing the Mishna in *Avot*. Putting it in the language of contemporary ethicists: Is truth-telling, in Judaism, an absolute

6. R. Saadia ben Yosef al-Fayyumi (892-942). As Gaon and head of the academy at Sura, he was the intellectual representative and leader of world Jewry in his time. His *Emunot V'Deot* is the first systematic presentation of Jewish philosophy. The original work was written in Arabic. It was translated into Hebrew by Yehuda ibn Tibbon c.1186. A scholarly translation into English is also available. (See note 8 below.)
7. *Emunot V'Deot*, Introductory Treatise: ch. 5.
8. English translation of *Emunot V'Deot*: Saadia Gaon, *The Book of Beliefs and Opinions*, translated by Samuel Rosenblatt, (New Haven: Yale University Press, 1948), p. 16. The term in the Hebrew is מדע השכל.
9. Saadia, *Emunot V'Deot*, Treatise III: Chapter 2. Rosenblatt translation, pp. 142f.

duty — an unconditional duty which holds in all circumstances — or a prima facie duty — one which can be set aside by other duties of higher priority or greater weight?

It has been argued[10] that truth-telling is a prima facie duty, not an absolute one, as illustrated in *Genesis* 40:15-17, wherein the brothers of Joseph fabricate a message from their recently deceased father, for the purpose — in their perception — of maintaining peace within the family and possibly saving their own lives.

Also in the Torah (*Genesis* 18:12, 13) G d informs Abraham, who is then ninety-nine years old, that he and his wife Sarah, eighty-nine years at the time, will have a child. Sarah, overhearing this, laughs disbelievingly within herself, saying, "After I am grown old shall I have [sexual] pleasure, and my husband is [too] old?!!" Yet when G-d reports Sarah's lack of faith to Abraham, for purposes of religious instruction, He alters her words and reports Sarah to have said, "Shall I indeed bear a child, and I am [too] old?!!" deliberately concealing Sarah's doubts of her husband's masculinity.

Commenting on the Talmud's exegesis of this passage, Rashi says: "Sarah had spoken degradingly, but when the Holy One Praised be He revealed the matter, . . . He altered the matter for the sake of peace." The Talmud, there, emphasizes, "Great is peace, for even the Holy One Praised be He alters [the truth] for it." In certain cases, peace takes priority over truth.

Another example occurs in the same section of talmudic commentary. The Biblical reference is *I Samuel* 16:1, 2. In this passage, God, who is displeased with King Saul, commands Samuel to go to Bethlehem to appoint another king. But, objects Samuel,

10. Nechama Leibowitz, *Iyunim B'Sefer Bereshit*, (Jerusalem: Department of Education & Culture of the World Zionist Organization, 1970), pp. 403-407. (Also available in English translation)
11. *Yevamot* 65b. My teacher, Rabbi Morris J. Besdin of blessed memory, suggested that it was more than interpersonal peace between man and wife that G-d was protecting. He was also sensitive to Abraham's internal peace and wholeness; G-d protected him from a crushing blow to his ego.
12. Leibowitz, ibid.

"How can I go? If Saul hears it, he will kill me." And the Lord said, "Take a calf with you and say, 'I am come to sacrifice to the Lord.' "

God has provided the prophet with a subterfuge by which to avoid the king's wrath and preserve his own life. The Talmud (quoting Rabbi Ila'a in the name of Rabbi Elazar b. Shimon) cites this incident to prove that it is not merely *permissible* to alter the truth; it is *obligatory*. Rashi sums it up: "The Holy One Praised be He *commanded* [Samuel] to alter [the truth]."

The Talmud, in its discussion of the preceding passage, compared the relative weights of truth-telling and the promotion/preservation of *peace*. Bakhya ibn Pakuda in his *Duties of the Heart* spells out the competing duties as truth-telling and the preservation of *life*. The preservation of life is one of the highest duties. One who fails to take precautions, where indicated, to protect himself from death, commits a grave sin. Even though the prophet was setting out on a divine mission, he was cautious about danger to his life. Lesser human beings, says Bakhya, certainly need to be cautious and not depend on faith alone where mortal danger is involved. The method (subterfuge) commanded by G-d to Samuel is not exceptional; it is paradigmatic. Preservation of life takes priority over truthfulness.[13]

As we shall see below, the duty to preserve life outweighs not only truth, but almost all other commandments of the Torah as well.

II. "Moral Traces"

In the preceding section we established that truth-telling/avoidance of deceit is a prima facie duty which must be waived for the sake of peace or for the preservation of life. However, when for reasons of these overriding duties, we are obliged to waive the duty of truthfulness, do we do so without reservation? When the halacha permits — or even requires — a lie,

13. *Duties of the Heart*, "Treatise on Faith": Chapter 4, as cited by Leibowitz.

can the lie be told without compunction? Is it considered wholly meritorious, or does the waiver of truth-telling by an overriding duty leave some vestige of wrongfulness attached to the lie?

Among contemporary secular ethicists there is some discussion about the status of a prima facie duty which has been overridden or outweighed by other duties. Even though the overridden duty is non-operative in the specific situation, it nevertheless remains morally relevant. In the view of these ethicists, such an overridden duty "does not simply disappear or evaporate. It leaves what [Robert] Nozick calls 'moral traces,' which must be taken into account. Although such a duty is not operative, there are traces of its violation. Every attempt must be made 'to minimize the effects of the violation'."[14]

Tension arises whenever a duty or commandment is waived or deferred by another duty or commandment.[15] A classic example in the Talmud and the Codes is that "any possible danger to life displaces [the laws of] the Sabbath" — and other laws as well (כל ספק נפשות דוחה את השבת). This operating principle having been stated by the Mishna, the Gemara almost immediately goes into a discussion of how — in another instance, when the dietary laws are to be displaced by the needs of a seriously ill person — the violation of the displaced laws should be minimized.[16]

14. Beauchamp & Childress, pp. 45, 47. The authors cite Robert Nozick, "Moral Complications and Moral Structures," *Natural Law Forum*, 13 (1968): 1-50.

15. I am not referring here to the specific mechanism of עשה דוחה לא תעשה ("a positive command displaces a negative command" — where in conflict). That mechanism is not applicable to our discussion, for two reasons: (1) the prohibition against falsehood is not an איסור לאו (a "Thou shall not"), but rather an איסור עשה (a prohibition deriving from a positive command, viz. "Keep far from a matter of falsehood"); (2) speech is not considered an action.

16. For detail see *Yoma* 83a; note the discussion of בולמוס starting with and following the Mishna. See also Maimonides, "*Hilchot Shabbat*" 2:1.

In another place (*Menachot* 63b-64a), the Talmud engages in considerable discussion to explain the reasons of the sages for not adopting the views of Rabbi Yishmael and Rabbi Chanina. The minority view of these two *tannaim* was that even though the prohibitions of the Sabbath are displaced by the commandment of harvesting of the *Omer* on the proper date, the violation of the Sabbath should be kept to a minimum. The sages — the authoritative majority —

The key word in the above is דחויה — displaced (or very literally "pushed" aside). There are other ways, however, in which a commandment or prohibition may be made non-operative. One such way is when a conflicting halachic requirement has the effect of transforming a prohibited act into a permitted one. When prohibited becomes "permitted" — הותרה — there is no trace of any violation; that which is permitted in a specific situation may be done without any reservation, even though the same act might ordinarily violate a prohibition.[17] It must be kept in mind, however, that the "permission" is limited in scope and does not exist where not generated by the conflicting duty.[18] Even though there is no violation, therefore, circumspection is required to avoid stepping outside the limited conditions of the "permitted" prohibition — the conflict of requirements which generates "permitted" status — and committing a violation.

One might arrive at the misimpression that a third way in which a prohibition may be made non-operative is by its being transformed into a positive commandment. Rabbi Ila'a was quoted above as saying that in certain instances lying is a mitzvah — a commandment or obligation. This can easily be misunderstood. As Maimonides explains, the laws of the Torah can never be contradicted, even by a prophet, except as a "ruling of the hour" for a unique exigency; a prohibition cannot, otherwise, be turned

are required to provide ample reasons, discussed in the Gemara, to justify their position. (Their principal reason had to do with public education in an area of polemic dispute between the sages and the Sadducees, a deviant group.)

Maimonides, "*Hilchot Shabbat*" 1:7,8 codifies two important examples brought by the Talmud (*Menachot* 64a) which show (1) that life-saving pushes aside the prohibitions and penalties of the Sabbath; and (2) that, wherever possible, the violations should be minimized. i.e. the prohibitions, although displaced, still carry a trace of "violation," even though non-culpable.

17. This distinction between הותרה and דחויה is made in *Pesachim* 77a and applied in 79a (starting with the Mishna). See also Maimonides, "*Hilchot Bee-at HaMikdash*," 4:15.
18. An example of this is the "permitted" performance of the daily burnt offerings in the Holy Temple at the *required* times, even on the Sabbath, although the act of burning is strictly prohibited on the Sabbath under ordinary conditions.

into a positive commandment.[19] The statement of Rabbi Ila'a does not mean that lying is a positive command — not under any circumstance. Rather, what is meant is that life-preservation is a positive command and that lying is the necessary means for its fulfillment under certain circumstances. The prohibition[20] against lying is, then, either "displaced" or "permitted" under those circumstance — not made into a positive commandment.

It is evident that the halacha makes a distinction between two types of overridden, non-operative prohibitions. Such a prohibition might have been: "displaced" (דחויה); or "permitted" (הותרה). Only in the first of these is there any sense of violation which need be minimized. In the second, there are no "moral traces." It is difficult to determine or to prove into which of these two categories lying falls when its prohibition is overridden by life-preservation.

If "displaced," the violation should be minimized. One way to minimize violation is to be passive about it. This is the halachic notion of שב ואל תעשה — "Sit and don't do anything."[21] Since the prohibition against lying is technically a positive rather than a negative command,[22] its violation can be minimized by passively not telling the truth. That is fairly simple so long as the patient does not explicitly ask for information. When he does, however, advocates of "passive" suppression resort to evasion and

19. Maimonides, *Hilchot Yesoday HaTorah*, 9:1-4.
20. Actually it is an איסור עשה — a prohibition implied by a positive command (viz. "Thou shall keep far from a matter of falsehood") — rather than a directly stated prohibition. The legal effect is that violation does not technically involve an active transgression of a "Thou shall not," but rather the passive failure to observe "Thou shalt." The penalty is lower, but the ethical effect — infidelity to the truth — remains the same.
21. This approach is employed even to override Torah law by man-made rabbinic law. A good example is the rabbinic injuction against sounding the Shofar on a Rosh Hashana coinciding with the Sabbath, even though the Torah commands it to be sounded on Rosh Hashana. The rabbis, concerned that the Shofar would be carried from place to place in violation of the Sabbath, legislated that it was not to be sounded. This they were able to do by means of the notion of שב ואל תעשה — passive non-compliance with the Torah command.
22. See note 20 above.

obfuscation. Though their intent is "benevolent deception," they pride themselves on not having told a lie.

If an actual conflict exists between life-preservation and truth-telling, then the use of "passive" suppression is an admirable attempt to minimize or avoid a violation even though it is overridden and non-operative. If such a conflict does not exist, then "passive" suppression is no more than a circumvention of a fully applicable duty.

Regardless of whether the prohibition against deceit is "displaced" or "permitted," it can be so only if an actual or possible (ספק) conflict of duties exists. Such a conflict or the possibility thereof must be *real* and not merely *presumed*. For if it is presumed too easily, without good basis, the result may be unjustified lying or unwarranted "passive" suppression.

III. The Halachic View of Truthful Disclosure to Terminal Patients

The preservation of life is one of the highest of practical duties. With the exception of three prohibitions and the requirement of sanctifying G-d, any and all of the commandments of the Torah must be put aside when in conflict with the duty to preserve life.[23] Even if the danger to life is remote or uncertain, halacha takes no chances; the "doubtful danger" is to be treated as though it were a certain danger, requiring the overriding of any other duties that might possibly conflict with life-preservation.[24]

23. *Yoma* 82a states the priority of life-preservation as follows:
אין לך דבר שעומד בפני פקוח נפש חוץ מע"ז וגילוי עריות ושפיכות דמים
The priority of life-preservation over the other laws of the Torah is learned from the Torah itself, which instructs, "Ye shall keep My statutes and My laws, which a man shall do them *and live by them*." (*Lev.* 18:5) "Live by them and not die by them," the sages learned. (*Yoma* 85b).

24. *Yoma* 83a ספק נפשות להקל — In case of "doubt of mortal danger, [we are] lenient [with regard to the observance of conflicting commandments]." The nature of the doubt discussed by the Gemara is a difference of opinion amongst expert physicians or between patient and physician, regarding the needs of the patient or the seriousness of his condition.

Psychological factors are considered, too. A lamp may be kindled on the Sabbath, for example, in the room of a seriously ill patient even though the patient be blind because, says the Talmud, the patient will have a greater sense of security if she senses that her caregivers can see. Concern for the patient's state of mind or emotionall well-being is adequate reason to override even the Sabbath;[25] state of mind has an effect upon health and life.

Hopelessness as a cause of death has been repeatedly demonstrated. Rabbi J. David Bleich cites several studies and experiments which confirm or strongly suggest this conclusion. Researchers conducting one such experiment, performed on rats, attributed death of rats in the experiment to "emotional reactions" causing "overstimulation of the parasympathetic system." The specific emotional reaction tested was hopelessness. Other studies involving human beings have produced similar findings, connecting the emotional state of hopelessness with a resulting deterioration in circulatory and neurological functions leading to premature death.[26]

Sissela Bok also writes that a sense of hopelessness or an attitude of giving up in the face of the inevitable has been seen to trigger "physiological mechanisms which allow death to come more quickly."[27]

The obvious implication for halacha is that anything which might produce a sense of hopelessness in the dying patient must be carefully avoided. Since depression and despair can hasten death, everything possible must be done to maintain hope.

25. *Shabbat* 128b. The case involves a woman in childbirth on the Sabbath.

26. J. David Bleich, *Judaism and Healing: Halakhic Perspectives*, (New York: Ktav Publishing House, 1981), pp. 30, 31.

27. Sissela Bok, *Lying: Moral Choice in Public and Private Life* (N.Y.: Vintage Books, 1979) p. 248. The author cites the research of Lewis Thomas, who describes "a pivotal moment . . . when the organism concedes that it is finished and the time for dying is at hand, and at this moment the events that lead to death are launched, as a coordinated mechanism. Functions are then shut off, in sequence, irreversibly, and, while this is going on, a neural mechanism, held ready for this occasion is switched on." (This quotation from Thomas can be found in "A Meliorist View of Disease and Dying," *The Journal of Medicine and Philosophy*, 1 (1976), pp. 212-21).

The preponderance of halachic sources presume that unhappy news has an almost automatic and nearly universal hope-crushing effect. Bad news is depressing and must, therefore, be suppressed from the seriously ill person.

The *Shulchan Aruch* instructs caregivers and visitors not to inform a terminally-ill patient of the death of a close relative for whom he would normally be obliged to mourn, lest he become emotionally "torn-up over it" (שמא תטרף דעתו עליו.) Furthermore, we must not carry out any of the practices of mourning in his presence — even if he has learned of the death, according to the commentary of the *Shach*, because the full realization of such unpleasant news will "break his heart" (ישבר לבו). The *Shach* adds that the subject of the death of even a stranger will cause the patient to fear his own death. Therefore, says the *Shulchan Aruch*, we are to *silence* those who might come to console him (משתיקין מפניו את המנחמין).[28]

The approach advocated by the Codes and by their original sources in the Talmud may go back even further. In *II Kings* 8:7-10 Ben-Hadad the king of Aram sends a messenger to the prophet Elisha to inquire of the prophet whether or not the king would recover from his illness. The prophet tells the messenger to go back and tell the king, "'You shall surely live,' even though G-d has revealed to me that he shall surely die." Bleich cites this text, as well as a number of rabbinic commentaries, to prove that Scripture itself provides the precedent for lying to a patient about his terminal prognosis. "Candor might hasten the death of the patient," says Bleich. "Lack of truthfulness, in such situations, is not merely

28. *Shulchan Aruch: Yoreh Deah* 337. The *Be'er Hagola* (a reference commentary) gives *Tractate Smachot* as the source for this ruling. I was unable to find the source in that tractate. Rabbi Y.M. Epstein in his *Aruch HaShulchan* (*Yoreh Deah* 337:1) tells us:

ולפנינו לא נמצא זה וכן כמה דברים הביאו הקדמונים ממס' זו ולא נמצא לפנינו כי אין נמצאת אצלינו במילואה.

The tractate is no longer extant in full; our versions of it are imcomplete. The ruling is, however, repeated (and cross-referenced to *Smachot* Chapter 9, by the *Mesoret HaShas*) in *Moed Katan* 26b near the bottom of the column.

permissible, or even commendable, but mandatory."[29]

In speaking of טירוף הדעת — the emotional "tearing-up" of the patient — the halacha is expressing a concern for the inner integrity or wholeness of a person. Halacha recognizes that the ability of a person to live is seriously affected by that inner sense of wholeness (שלימות). Certain things can have the effect of "tearing" it up, of crushing all hope, of so devastating a person that he will lose all will to live and will actually die of a "broken" spirit. Bad news about himself — such as a diagnosis of inoperable cancer affecting vital organs — is presumed to have such an effect.

The practice advocated by the halacha with regard to truth-telling is, then, clearly founded upon the opinion that there is always, or almost always, a conflict of duties between life-preservation and truth-telling. In the next section we shall explore to what extent this conflict does indeed exist.

IV. Contemporary Clinical Evidence and Opinion

The Arguments Against Truth-Telling

In secular literature three arguments are used to support suppression of the truth and even direct deception of the seriously ill or dying.[30]

The first argument is that knowledge of the truth will harm the patient. This is the view of the halacha. Telling a patient that he has a serious illness from which he may possibly die might cause him to die faster. Since the duty to preserve life overrides the duty to be truthful, lying becomes permissible and even obligatory.[31]

The second argument is that patients do not really want the truth. Regardless of what they say about it, they would rather not

29. Bleich, pp. 28-29. Immanuel Jacobovits, *Jewish Medical Ethics*, (New York: Bloch Publishing Co., 1959), pp. 120-21 makes the same point.
30. See Bok, p. 239ff and "Editorial: On telling dying patients the truth," *Journal of Medical Ethics*, 8 (Sept. '82) pp. 115-16.
31. Bleich, p. 29.

be told bad news. The belief in this position is supported by a certain demonstrable percentage of patients who, indeed, deny what they have been told about their disease.[32] Although this argument is not used by the halacha, it warrants mention here, because in some of the clinical evidence and opinions which follow, the phenomenon of denial or partial denial is connected with the issue of hope and morale, which have direct bearing on the first argument.[33]

The third argument is that it is "impossible successfully to communicate the truth." This is because of the lack of *absolute* knowledge and certainty on the part of the medical profession; the inability of the patient to understand; and flaws in the communication process. The "truth" that is conveyed may not turn out to be the truth. Since perfect truth is unattainable, according to this argument, "it does not matter whether or not we lie when we have good reason to do so."[34] Although I have heard this argument cited verbally by adherents to the halacha, I have not found it in

32. One study conducted in England during the late 1950's looked into just this point. 231 cancer patients were included. 7% disapproved of having been told, 19% denied they had been told, and most of the remainder "said they were glad to know the truth." See Jean Aitken-Swan & E.C. Easson, "Reactions of cancer patients on being told their diagnosis," *British Medical Journal*, (March 21, 1959), pp. 779-83.

Another study conducted in the United States by Gilbertsen and Wangensteen "Should the doctor tell the patient that the disease is cancer?: surgeon's recommendation," in *The Physician and the Total Care of the Cancer Patient*, (New York: American Cancer Society, 1962), pp. 80-85 "found that 4% of a sample of surgical patients appeared to become emotionally upset at the time of being told and remained so throughout the course of their illness." — Cited in: Ned H. Cassem and Rege S. Stewart, "Management and Care of the Dying Patient," *International Journal of Psychiatry in Medicine*, Vol. 6(1/2) 1975, p. 297.

33. It should be noted, however, that clinical evidence belies this argument. The results of one British study, for example, "indicate that patients are likely to appreciate truthful information. Most were not acceptant of the silence, the untruths or the inadequate opportunities to talk seriously." — John Hinton, "Talking with people about to die," *British Medical Journal*, Vol. 3, (July 3, 1974), p. 26.

See also the studies cited in the previous note.

34. Bok, p. 12.

any of the halachic literature. It is its absence from the halachic discussion that merits mention here. That absence, as well as its own logical weakness, rules out the argument from any further discussion on our part.

Let us then return to the first argument — the only one that we need to consider — and examine the evidence and the expert opinions based upon experience that are available to us.

It is well known that "treatment is enhanced by a favorable psychological environment." Panic or severe depression adds acute stress to existing disease.[35] Very bad news abruptly conveyed or given to someone unable to tolerate it can trigger panic or severe depression and set into motion a physiological reaction which Sissela Bok calls a "dying response."[36] This has been seen to occur often enough to warrant considerable caution and skill in speaking with the seriously ill patient.

An example of the lack of such caution, skill, and sensitivity and of the harm which can be brought upon the patient is related by Dr. Lawrence Goldie of the Royal Marsden Hospital in London:

> One patient . . . not suspecting that anything serious was amiss, went to hospital for "blood test." Subsequently, because of the nature of the results, an appointment was made for him with a physician. Without preamble, the consultant presented him with the news that he had a very serious form of leukaemia! The patient collapsed and was incontinent of urine and faeces.[37]

Such callousness and rough technique on the part of the physician induced an emotional response from which the patient may never have recovered. Poor technique of this sort, and/or the

35. Norman Cousins, "A layman looks at truth telling in medicine," *Journal of the American Medical Association (JAMA)*, Vol. 244, No. 17 (October 24-31, 1980), p. 1930.

36. Bok, p. 248,49. See above, note 33.

37. Lawrence Goldie, "The ethics of telling the patient," *Journal of Medical Ethics*, Vol. 8 (September 1982), p. 129.

lack of follow-up while the patient digests the information are, in Goldie's words, "like performing a skillful surgical operation and then leaving the skin unsutured, the wound uncovered, and the patient deteriorating."[38] That the consequences are disastrous should be no surprise.

On the other hand, truthful disclosure and open conversation with the gravely ill patient is often the very thing that the patient needs and from which he can benefit.

Benefits

Numerous studies and a wealth of clinical experience reveal that the "risks of disclosure" [have been] grossly overestimated,"[39] while, on the other hand, the benefits are substantial, even measurably so.[40] Fear and anxiety are reduced; co-operation with treatment is improved; pain, understood, is better tolerated; isolation from family and caregivers is relieved, giving the patient the emotional benefit of genuine human contact.[41] No one study would be proof in itself, due to limited sampling and possible quirks in procedure. When taken together, however, there is a substantial weight of evidence which the halacha cannot but take into account.

Amelioration of Anxiety

Fear of the unknown can be one of the most debilitating of all emotions. "Lack of information can greatly increase anxiety and stress," leading to severe depression and withdrawal from the struggle of life. Knowledge can dispel the fear, and reduce the level of anxiety.[42] "Corrosive worry" about what is unknown, but

38. *Ibid.*, p 132.
39. Maxwell Boverman, "Truth telling in medicine," a letter in *JAMA*, Vol. 248, No. 11 (Sept. 17, 1982) p. 1307.
40. Bok, p. 247.
41. Aitken-Swan & Easson, p. 782.
42. Thurstan B. Brewin, "The cancer patient: communication and morale," *British Medical Journal*, Vol. 2 (Dec. 24-31, 1977), pp. 1627.

vaguely suspected, can be more debilitating than knowledge of unpleasant facts.[43] Some patients in a British study verbalized it well:

> "If they don't tell you, you just keep worrying and wondering, 'Have I got it?' so it's much better to know." "If you know what's the matter you know what to expect, but if you're in the dark and they're treating you for this and that and you don't really know, it worries you more." "A person worries more if it's a mystery."[44]

It is for this reason that numerous studies have reported results, "indicating that most patients with a potentially terminal disease wish to be fully informed about their illness and its management."[45]

In one study, published by John Hinton, a comparison was made of the moods and opinions of 80 terminal patients receiving equally adequate medical care in four different types of setting: a hospice for the terminally ill, in which "patients could readily discuss their condition and the possible outcome, including dying"; a foundation home for cancer patients, whose communication policy "was for greater reticence about cancer or dying unless patients were clearly intent on knowing"; an acute hospital's radiotherapy wards in which "frank talk about dying was infrequent"; and hospice outpatients dying at home.

The study showed unambiguously that patients were least depressed and anxious at the hospice and firmly favored the more open communication available there. The setting "with freer communication had less anxious and irritable patients . . . and, perhaps, less depressed patients . . . Hospice patients were significantly less troubled over the outcome of the illness. . . Acceptance of dying tended to be less troubled with more liberal

43. Bok, p. 247.
44. Aitken-Swan & Easson, p. 780.
45. Patricia M. Reynolds et. al., "Cancer and communication: information-giving in an oncology clinic," *British Medical Journal*, Vol. 282 (May 2, 1981) p. 1451.

debate," while conversely, the "less open approach was associated with more troubled patients."[46]

Improved Attitude toward Treatment and toward Pain

Seriously ill patients experience a sense of loss of control in the hospital environment. Doctors, nurses, and technicians are doing things *to* them. Tests, operations, and procedures are being performed *upon* them. They may be so weak as to require help even in attending to their personal, private, hygiene needs. The patient often, even usually, feels that he is an imprisoned body being acted upon by others. The mood of depression induced by this state of affairs is anything but the "favorable psychological environment" which enhances treatment.

An explanation by the physician to the patient — of what is known about his disease; of the methods and purposes of diagnostic tests; of the symptoms and sensations that might be expected; and of the benefits that might be achieved by various forms of treatment, even if they be only palliative — gives the patient the sense that he is part of his own care, that he is an active participant *with* the doctor, rather than an imprisoned body being manipulated by others. While being truthful about the medical problems and the pain and discomfort that might be expected, the doctor can, at the same time, place emphasis upon his hopes for benefit from treatment — no matter how limited — and tell the patient what he, the patient, can do to enhance the effectiveness of that treatment. Even the doctor who has nothing to offer other than medication to suppress the pain of an inoperable cancer, can give the patient the assignment of eating well to "keep up your strength." In my own experience, I have seen a despondent patient take on new strength and resolve *after* being informed of his terminal diagnosis by a doctor who gave him the hope of pain-control and the assignment to eat as he could. Prior to being informed of his diagnosis, the patient had been considered a

46. John Hinton, "Comparison of places and policies for terminal care," *Lancet*, January 6, 1979, pp. 29-32.

suicide-risk due to his bewilderment, pain, and severe depression.

This experience is consistent with the findings of a number of studies which have reported that "even when the news is bad, patients often express relief because the truth removes doubt and gives them a rational explanation" for tests and procedures and "for the concern of their doctors."[47] Aitken-Swan and Easson found that patients "felt that to know the truth helped them to fight better, it gave them additional resources to call on, they submitted to treatment in a different spirit, and they worried less."[48]

Relief from Isolation

Isolation or abandonment by others ranks high on the list of fears and complaints of dying patients.[49] Avoidance, by caregivers, of patients whom they feel unable to help is only one form of this problem. The patient can usually sense that others have given up on him. He may be angry about it. Or he may give up on himself, too.

Relevant to our study is another form of isolation — isolation from genuine human contact, emotional isolation — which affects the dying patient to his detriment. Whenever anyone is withholding or concealing the truth, he must necessarily withhold more than only some information. It is inevitable that he withhold a large part of himself. When a person is not open, he is not real, he is not genuinely himself. Despite the pleasant facade of one who is concealing unpleasant facts or feelings, the patient can almost always sense that it is a facade, that the person facing him is not "all-there," that there is what I would call an invisible sheet of plexiglass between himself and the well-intentioned concealer or suppressor. The dying patient is, in this way, deprived of genuine human contact — which he needs now more than ever.

Genuine human contact is not only comforting; it may be the link to "This World" that makes a person want to continue to live.

47. Goldie, p. 132.
48. Aitken-Swan & Easson, p. 782.
49. Cassem & Stewart, pp. 295 & 302.

Concealment and suppression usually result in "procedures [which] intensify the sense of distance and uncertainty and can even become a substitute for comforting human acts."[50] The very tension and unhappiness that we seek to avoid are instead induced, "as the patient begins to sense that his family, whom he had always trusted, are deceiving him and leaving him to suffer his fears alone."[51]

The dying patient usually knows that he is dying. He "knows that his wife knows, but they do not speak of it to each other! . . . This restriction on free speech, and the truth, disrupts any normal intercourse, so that couples instead of growing together, wither in each other's arms."[52] I have seen this happen, in one case, even where the facts were not concealed but where husband and wife attempted to protect each other from emotional pain by hiding their true feelings. The intense stress was relieved and the burden lightened when they were able to be truthful and genuine with each other — when they were able to touch each other emotionally. The ability to talk freely and openly, to share the burden, lightens the load and keeps the patient in contact with the world of the living.[53]

Contraindications and Precautions

Adverse Reactions

In a small but not insignificant number of patients, truth-telling, no matter how well it is done, produces the adverse reaction feared by the halacha — the reaction which has been described as a "dying response." Others unable to tolerate the truth are capable of forgetting or denying it even after having been told.[54] In either

50. Bok, p. 244.
51. Charles Fletcher, "Listening and talking to patients," *British Medical Journal*, Vol. 281 (Oct. 18, 1980) p. 1057.
    See also Richard T. Silver, "The dying patient: a clinician's view," *American Journal of Medicine*, Vol. 68 (April 1980) pp. 473-75.
52. Goldie, p. 128.
53. Cassem & Stewart, p. 300.
54. See above, no. 32.

instance, concern for harm to the patient (as well as respect for the patient's implicit wishes) requires that such a person be allowed to remain in as much ignorance as he or she desires or needs.

For this reason, the method employed by the truth-teller — often but not necessarily the physician — must include prior and ongoing assessment of patient response, in order to detect any adverse reaction and to alter or discontinue "administration" of the truth as appropriate. There is nothing strange or unusual about this; medication is often administered in much the same manner.

Methods of Assessment and Administration

Most advocates of truth-telling emphasize the importance of doing so responsibly; of being available and present to the patient for any signs of distress; of being available and present to the patient as he or she absorbs and digests the information; of exercising good judgment, timing, and sensitivity to the patient's mood; and of not imposing information upon the patient when he or she is not prepared to accept it — even if that means never.

The manner in which the information is conveyed is as important as the information itself in determining the nature of the patient's response to it. Anxiety and fear can be more than reduced; they can be subordinated to hope. Even the most dismal statistic — if the patient's personality and intellect make statistics appropriate — can be conveyed in a manner which, without lying, leaves a "route-out," a reason to hope for survival. While some patients do not like to dwell upon the unpleasant once they already know about it — and they should not be forced against their will — with other patients "optimism carries more conviction when salted with some unpalatable facts and possibilities,"[55] which give more credibility to the doctor as "not hiding anything."

Not all patients react the same way to truth-telling, and disclosure needs to be "administered" in accordance with the needs of the patient.[56] Some patients, "tense and suspicious that they are

55. Brewin, p. 1626.
56. See Hinton, "Talking with people about to die," for a broad sampling of the

being kept in the dark, badly need more information," but not necessarily every last detail.

Other patients feel ill at ease with technical explanations. Such a patient is concered with "immediate needs and fears," and not with "diagnostic labels or long-range forecasts."

Some desperately hope for reassurance that their condition is not dreadful or try to maintain "aggressively cheerful optimism." Such a patient "will be deeply upset, or angry, or both . . . if given a diagnosis or prognosis that he is striving to reject."[57]

Other patients want the full facts. Nevertheless, the truth-teller might need to assess whether the patient will appreciate or despise guarded optimism, and whether the patient will tend to put an optimistic or pessimistic slant on such words as "possibly" or "probably."[58]

A number of different methods have been used to determine how much information should be given to a particular patient. In an experiment conducted in Australia, patients were given a choice about the types of information they would like to receive. The categories of information were: (1) diagnosis; (2) treatment; (3) symptoms to be anticipated; (4) examinations and tests that will be necessary; (5) palliative measures available; (6) prognosis ("what the outcome might be"). The vast majority of patients elected to receive information in all the categories. The highest percentage — 97% — wanted to know about "tests, treatments, and side effects." The lowest percentage — 88% — wanted information about prognosis. Patients were given exactly, and only, the information that they requested. No adverse reactions were experienced. Subsequent follow-up, at five days and at six weeks, showed a high level of recall and understanding by patients of what had been told to them. The researchers also found that this method, of "explicit categorisation," had averted the situation of "some patients being

variety of patient response to and desire for the truth, as reflected in their own words.

57. Brewin, p. 1624.
58. *Ibid.*

provided with information they did not wish to have."[59]

Another method, suggested by Cassem and Stewart, is for the physician to tell the patient, *prior* to the diagnostic workup, that "after all information is gathered, the two of them will sit down . . . in private to discuss the test results. This gives those who don't want to know or who want someone else to know instead of them a chance to say so."[60]

Some patients give mixed messages, indicating confusion about the facts and verbalizing a desire for information, but not really wanting to know, if it is unpleasant. Such a patient will usually forget or deny having being told, even if informed repeatedly.[61] When speaking with a person who might fall into this category, it is best to use non-specific, somewhat vague terminology to begin with. Names and labels need not be placed upon this disease initially. If the patient wants more specific information, he will make that clear and the information may then be given. If, on the other hand, the patient is afraid to know or emotionally unable to deal with bad news, this will become apparent and the information can be withheld.[62]

Receptivity and response to unpleasant information varies not only from patient to patient, but even within the same patient from day to day or from hour to hour. A patient's mood may be affected by "varying proportions of acceptance, denial, optimism, and pessimism,"[63] by his or her level of pain, by a fluctuating degree of difficulty in eating and in bodily functions, and by extraneous factors such as interpersonal relationships and changes in the weather.

The truth-teller must, therefore, be sensitive to the individual patient and to the mood of the moment. Before disclosing — or

59. P.M. Reynolds *et. al.*, pp. 1449-51.
60. Cassem & Stewart, p. 297.
61. Bok, p. 242.
62. Brewin (p. 1626) advises "talking to the patient in such a way that he is, in effect, given the choice of . . . denial or acceptance."
63. *Ibid.* p. 1624.

while in the midst of disclosing — an unfavorable diagnosis, an assesment must be made of the patient's receptivity, so that the truth not be imposed upon someone who might be harmed by it. "Sometimes a vital clue," says Brewin, "is not the patient's first question, but his second question (or the absence of a second question), after we have begun to give him some explanation of what is going on, watching to see how he takes it. The patient . . . guides us as to what we should say."[63a]

This last point is very important. Too often people put themselves into the shoes of others and guess or fantasize what other people think and feel. Goldie describes the harm inflicted upon others when we act upon such fantasy or self-projection instead of investigating the actual mental/emotional state of the patient:

> Mr. P decided, when his [terminal] cancer . . . was discovered, to forego any treatment for it. A year later he was referred to the psychotherapist because he was thought to be "depressed." When interviewed it turned out that he was depressed because his vision was blurred and he could not co-ordinate sufficiently to write. And this, it turned out, was due to the side-effects of three drugs which were "anti-depressants" and tranquilisers and three drugs which were for the relief of pain. He had been given these drugs because it was presumed that he would be in pain, yet he said he had never complained of pain. The tranquilisers were given because it was thought he would be anxious as death was close. He said that he was not afraid of dying but he was concerned about the possibility of dying through choking, with no relief available. In effect he had been given drugs without having a condition which required them, and his ability to think and act as he wished, constructively, had been taken away from him.[64]

63a. *Ibid.*

64. Goldie, p. 132,33. The author goes on to report that the drugs were stopped and the patient went home. There, he went over household affairs with his wife, teaching her how to do many of the odd jobs for which she had previously depended on him. He continued to live actively and without giving-up, until three days prior to his death, at which time his condition required re-admission to the hospital.

The halacha rules that a gravely ill person should not be told the severity of his condition, because the knowledge that his case is hopeless will cause him anguish leading to an earlier death. When such information would *not* be detrimental to his psychological or physical well-being, the halacha might not require or recommend such withholding. No policy or treatment or of truthful disclosure can be determined *a priori* and applied uniformly to all patients. To decide that the truth must be disclosed to or withheld from a given patient, without assessing the patient, "is equivalent to prescribing for patients without examination."[65]

Maintenance of Hope

One of the main concerns in the truth-telling debate is the assumption that hope and the truth are mutually exclusive — that hope cannot be maintained in the face of the diagnosis of a terminal condition — that the truth about such a condition can only prompt despair. The experience of many of those who deal directly with patients on a daily basis belies this assumption.

In the words of one clinician, "It is almost always possible to combine frank and accurate disclosure of the truth with an invigorating infusion of hope."[65]

Even the patient with terminal cancer can truthfully be told that there are statistically a few lucky, blessed, or highly motivated patients who survive when they are not expected to; that treatment to prolong life may well exceed the projections of its limited success; that miracles happen; that new treatments and cures are being developed constantly; and that with luck, blessing, and determination, "you can be one of those who beat the odds."

65. *Ibid.* Howard Brody, "Hope," a commentary in *JAMA*, Vol. 246, No. 13 (September 25, 1981), p. 1411.

Even when survival is not likely there can still be hope. "Hope is not automatically equated with survival. Hope means different things to different people; and hope means different things to the same person as he moves through different stages of his illness and his emotional reaction to it."[66] Hope may mean the ability to eat solid food and maybe even to enjoy a good meal. Hope may mean relief from pain, easier breathing, a better night's sleep. A dying person may strive to live longer — and succeed — in order to see a son graduated, a granddaughter married, the family together on a holiday. The 34-year old mother of young children may keep herself going from day to day on the hope of hearing her toddler talk, on the desire to be involved as long as possible in the lives of her husband and children. The religious person may look forward to participating in worship services or otherwise observing the next Sabbath or holy day.

While these extremely limited hopes may strike us as tragic and tear at our hearts, they may be cause for great optimism in the patient. I, myself, have seen hopes such as these serve as incentive for people to endure what *we* might regard as a "very poor quality of life," but in which they found value. (I have also heard of people's spirits being crushed temporarily over the news of impairments which *we* might consider minor.) If we *listen* to patients and learn of *their* concerns, we can almost always help them find realistic causes for optimism and for hope.

An experienced physician advises his colleagues "always to have a plan and to tell the patient what it is . . . . If there is a reasonable chance of achieving one or more short-term objectives (less pain, easier breathing, a better night's sleep), this needs to be explained to the patient in a suitably positive . . . way. Seldom, if ever, is it true to say that 'nothing can be done.' "[67]

The most necessary factor for maintaining hope in the patient is an air of hopefulness for him in those around him. An openness,

66. Brody, p. 1411.
67. Brewin, p. 1623. See also Silver, p. 474.

a willingness to talk and to listen to the patient, conveys a positive, hopeful attitude. By contrast, protective secrecy may be detected by the patient and interpreted as "something terrible and hopeless which they're trying to keep from me."

This does not mean that every patient should be told the truth. We have already cited evidence of the inability of some patients to tolerate it. Even the same patient who accepts and the truth at one point may deny or "forget" it at another point. He may understand the truth when he is with one person, and not know anything at all about it when he is with another person. Patients may move from acceptance to denial and back again, or vice versa. This movement is part of an internal hope-maintaining mechanism.

Regardless of what is or is not said to a particular patient at a particular time, however, morale is maintained by showing interest, which reflects hope, in the patient. Neither secrecy nor truthfulness can maintain hope, when imposed upon the patient against his mood and wishes. The question of hope does not end with whether or not the truth has been told. The maintenance of morale is dependent upon continued interest, attention, and openness to the patient throughout his illness.[68]

Summary of the Evidence

Summarizing the evidence presented in this section, we have shown that many persons afflicted with terminal illness desire information about the illness and about the nature and purpose of procedures and treatments. These patients benefit from such information, honestly and sensitively presented, in the following ways: amelioration of anxiety and fear; hopefulness for the potential benefits of treatment as described by the physician; better toleration of pain and discomfort; enhanced co-operation in and response to treatment; alleviation of much-feared alienation. All of these benefits make for a psychological climate conducive to a positive will to survive.

68. *Ibid.* p. 1625.

Some patients (19% in one study) who cannot tolerate bad news repress or deny it. Almost all patients are capable of momentary or partial denial, as needed, to protect themselves from intense psychological pain. A small number of patients (7% in a British study, 4% in an American study), incapable of tolerating or of denying bad news, experience a morale-damaging shock when informed of their disease.[69] This can be avoided, however, by careful assessment of the patient prior to and during information-giving, so that the information may be withheld from these specific patients.

The manner in which information is conveyed has an effect upon how it is received. Presentation must be tailored to the individual patient and to the moment. Continued attention and concern must be shown the patient following information-giving while he digests the full import of the information, and throughout his illness. Even when long-term survival does not appear possible, the situation is not hopeless. Limited goods, other than survival, can be hoped for and can provide motivation to go on.

V. Discussion

We have cited numerous studies and clinical findings — and there are many more which time and space do not permit us to include — which show that truth-telling often, though not always, benefits the terminally ill.

The tendency of advocates of suppression is to dismiss the findings of these studies as too subjective and unreliable. The concurrence of such a large number of independent researchers and clinicians, from a wide variety of backgrounds, dealing with diverse patients, is largely ignored.

The approach of many halachic scholars to this issue is typified by J. David Bleich, who says that the evidence and the findings[70] are

> essentially irrelevant to our concern . . . No universal

69. See above, n. 32.
70. Specifically those of Dr. Elizabeth Kubler-Ross, as though there were no others.

> generalizations may be drawn with regard to the reactions of all patients. Not *all* [emphasis is Bleich's] patients react in the manner described by Dr. Kubler-Ross. [Some patients experience] devastation . . . and consequent loss of a desire to live . . . The *possibility* [emphasis is Bleich's] of adverse reaction is sufficient reason for eschewing a policy of full disclosure. Jewish law is concerned with the foreshortening of even a single human life. Accordingly . . . the possibility of hastening death in at least some patients must be the determining consideration.[71]

It is well known that a statistical risk of death is present in almost every type of major surgical operation, in general anesthesia, and in certain invasive diagnostic procedures. Yet the halacha does not uniformly prohibit the use of these tests and treatments. Halacha looks not at actuarial tables, but rather at the risk/benefit ratio of the procedure as it applies to the specific patient who is contemplating it. The well-known halachic principle, somehow strangely ignored, but applicable here, is כל מקום דיכול לברורי מברינן — "wherever [we are] able to clarify empirically, we clarify empirically."[72]

The evidence and expert opinion based upon experience indicate that the benefits or risks of truth-telling to an individual patient can be assessed empirically in the course of treating the patient. With proper assessment and careful administration, the risks can be avoided/reduced, and life prolonging benefits can accrue.

The *Shulchan Aruch* itself prescribes truthfulness tempered with hope when imminent death is anticipated:

> [When the patient's condition has] leaned toward death, [we] say to him, "Confess." And [we] say to him, "Many have confessed and not died, and many

71. Bleich, p. 29.
72. Statistical rules and mechanisms — such as חזקה, רובא, ספק, קבוע and ספק ספקא — are employed in determining halacha only when/because there is no empirical means of determining the facts.

> who did not confess have died. And on the merit that you confess [repentance is implicit in confession], you may live. [i.e. Death is not certain; there is still hope.] Whoever confesses [thereby attaining reconciliation with God] has a portion in the World to Come."[73]

The *Shulchan Aruch*, as explained by the *Shach*, recognizes the emotional risks involved to the very fragile patient. Nevertheless, it prescribes that we minimize the risks — by not engaging in the confession in the presence of persons who tend toward emotional outbursts — and instruct the dying person to confess for his own spiritual benefit. Here is an excellent example of the relevance and application of risk/benefit ratio in truth-telling — with hope — to the dying patient. The risks of emotionally-induced harm cannot be reduced to zero. They are, however, reduced to a reasonable level when measured against the benefits.

The *Shulchan Aruch* and the sources from which it derives (as discussed in the *Shach*) reserve such candor for the very end — when death seems near. The reason for enjoining against truthful discussion during the earlier course of the illness is the presumption of high risk and no benefit.

But we have shown in the preceding section that the benefits deriving from openness and candor often place truth-telling on the side of life-preservation rather than in conflict with it. The practical halacha, therefore, is dependent on the effect which truth-telling will have.

VI. Conclusions

The insights of sages and prophets into human nature must be taken seriously. The sages were concerned about the adverse effects upon longevity of the seriously ill, which can result from disclosure/discussion of bad news. Any halachically valid approach must take into account this concern.

In some cases, halacha requires suppression of unpleasant

73. *Shulchan Aruch: Yoreh Deah* 338:1.

truth and even outright lying to the very seriously ill person. There are instances in which it has been determined that the patient will very likely react to the truth in such a manner as may result in the shortening of his or her life. In such instances, the truth stands in opposition to life. It is not lying that the halacha requires, but rather the preservation of life — with deception as the means.

In some cases, however, concealment of the truth may cause the patient more life-shortening stress than truthful disclosure and open discussion of the unpleasant. In such cases, where it has been determined that such stress can be reduced and survivability can be extended by means of truthfulness, the halacha requires the telling of truth *with hope*, and with sensitive and conscientious — but honest — spiritual and emotional support throughout the illness. Aside from the independent duty to avoid falsehood, the halacha requires the preservation of life — with truth-telling as the means.

It is our contentention that it *can* be determined, prior to or during the initial stages of disclosure, whether an individual patient can be expected to experience benefit or harm from knowing about his or her medical condition. Such a determination must be made, or at least attempted, prior to deciding upon a course of either concealment or disclosure.[97] To practice truthful disclosure upon

97. Three reasons can be offered for the message of benevolently deceitful optimism which the prophet Elisha sends the dying king of Aram. (See above):
(1) The patient regards the prophet as a messenger of G-d Himself. A terminal prognosis from the prophet would be taken as a death-sentence from G-d.
(2) Elisha was communicating to the patient only through a long-distance messenger. He would not be able to be there, in person, to help the patient digest the information, or to provide the "caring presence" that is such an essential part of the "pastoral care" of the dying.
(3) Through the power of prophecy Elisha knew not only the prognosis, but also the emotional reaction to bad news that could be expected *in the patient* — especially if the bad news came from him. His "assessment" of this patient — both physically and emotionally — was accomplished automatically through prophecy, without the need for examination.
I think it is safe to say that the occasion would be rare indeed in which any of these three reasons would apply to ordinary people, such as physicians, dealing with ordinary patients.

the patient who will die sooner on account of it, is a serious violation of the all-important duty to preserve life. To practice concealment/suppression/deception upon the patient who might live longer when he knows and understands his condition, is a double-violation: (1) the needless and unjustified breach of the principle of honesty; and (2) the failure to take availabile means to preserve or extend the life of another human being.