disadvantage that may arise from it to him or any other; and although by making a false statement I do no wrong to him who unjustly compels me to speak, yet I do wrong to men in general in the most essential point of duty, so that it may be called a lie (though not in the jurist's sense), that is, so far as in me lies I cause that declarations in general find no credit, and hence that all rights founded on contract should lose their force; and this is a wrong which is done to mankind.

If, then, we define a lie merely as an intentionally false declaration towards another man, we need not add that it must injure another; as the jurists think proper to put in their definition (*mendacium est falsiloquium in praejudicium alterius*). For it always injures another; if not another individual, yet mankind generally, since it vitiates the source of justice. This benevolent lie *may*, however, by *accident* (*casus*) become punishable even by civil laws; and that which escapes liability to punishment only by accident may be condemned as a wrong even by external laws. For instance, if you have *by a lie* hindered a man who is even now planning a murder, you are legally responsible for all the consequences. But if you have strictly adhered to the truth, public justice can find no fault with you, be the unforeseen consequence what it may. It is possible that whilst you have honestly answered Yes to the murderer's question, whether his intended victim is in the house, the latter may have gone out unobserved, and so not have come in the way of the murderer, and the deed therefore have not been done; whereas, if you lied and said he was not in the house, and he had really gone out (though unknown to you), so that the murderer met him as he went, and executed his purpose on him, then you might with justice be accused as the cause of his death. For, if you had spoken the truth as well as you knew it, perhaps the murderer while seeking for his enemy in the house might have been caught by neighbours coming up and the deed been prevented. Whoever then *tells a lie*, however good his intentions may be, must answer for the consequences of it, even before the civil tribunal, and must pay the penalty for them, however unforeseen they may have been; because truthfulness is a duty that must be regarded as the basis of all duties founded on contract, the laws of which would be rendered uncertain and useless if even the least exception to them were admitted.

To be *truthful* (honest) in all declarations is therefore a sacred unconditional command of reason, and not to be limited by any expediency.

Respect for Patients, Physicians, and the Truth

SUSAN CULLEN AND MARGARET KLEIN

Cullen and Klein argue that deception to benefit patients is wrong because it disrespects them by restricting their freedom to make choices about their own lives. But if a patient explicitly states that she does not want to know the facts about her condition, generally physicians should respect her wishes. Those who claim that it's not possible to tell patients the truth are confusing the "whole truth" with the "wholly true." Patients cannot and need not understand the whole truth—that is, all the medical details of a disease process. But they can understand enough to appreciate the nature and seriousness of the disease and the benefits and risks of treatments. Cullen and Klein concede that in rare cases, it is permissible for doctors to deceive a patient—but only if the deception is for a short while and if the potential gain from the deception is probable and significant. By this criterion, a brief deception to save the patient's life may be justified.

A long tradition in medicine holds that because medicine aims to promote the health of patients, it is permissible for a physician to deceive a patient if the deception would contribute to that end. "The crucial question," as one writer observes, "is whether the deception is intended to benefit the patient."[1]

Thus, according to this view, if Dr. Allison tells Mr. Barton he is making a good recovery from a kidney transplant, when in fact the transplanted kidney is not functioning well and his recovery is slower than expected, Dr. Allison's action is justified on the grounds that she is trying to keep up her patient's spirits and encouraging him to fight to regain his health. A sick person isn't made better by gloomy assessments.

This deception-to-benefit-the-patient (DBP) view has a prima facie appeal. At the least it is motivated by the physician's effort to do something to help the patient. Were a physician to tell a healthy patient he had a vitamin deficiency so she could sell him vitamin supplements or recommend unneeded surgery so she could collect a fee for performing it, we would condemn such actions outright. The physician is practicing deception in such cases to benefit herself, not the patient.

We all realize that a physician wouldn't be justified in engaging in just any form of action to benefit her patients. We reject as morally grotesque, for example, the notion that a surgeon should remove the vital organs from a healthy person and use them to save the lives of four others. Having the aim of benefiting a patient does not license using any means whatsoever. Rather, the physician must use means that are morally acceptable. While deceiving a patient for his own good is very different from killing an innocent person to provide the patient a benefit, we will argue that such deception is nonetheless wrong. In all but the rarest cases, deceiving a patient "for his own good" is an unacceptable way for a physician to try to help her patient.

Respect for Persons

While the DBP view seems unobjectionable at first sight, it is wrong for the same reason it is wrong for a physician to tell a healthy patient he needs vitamins so she can benefit from selling them to him. Such behavior is wrong (in both cases), because it doesn't treat a human being with respect.

Humans are, at the very least, rational beings. We have the capacity to guide our actions on the basis of deliberation, rather than being moved only by instinct or psychological conditioning. Our ability to reason makes all of us worth more than a tree, a dog, or maybe anything else in the natural world.[2]

If we are each special because of our ability to make choices, then others should not destroy this ability or interfere with our exercise of it. All of us have an equal right to choose how to lead our lives, and others have a responsibility to respect that right. (Working out arrangements allowing each person maximum freedom while also guaranteeing the freedom of others is a major task of social and political philosophy.) Treating humans with respect means recognizing their autonomy by allowing them the freedom to make choices about their lives. By contrast, to disrespect people means taking away their freedom to live as they choose.

Disrespect and the Physician's Good

If Dr. Mires, a gynecological surgeon, tells Ms. Sligh she needs a hysterectomy, when in fact the medical indications are insufficient to justify the surgery and he is recommending it only for the money he will receive for the operation, Dr. Mires is treating Ms. Sligh with disrespect. By lying to Ms. Sligh, Dr. Mires is damaging her autonomy. She is put in the position of having to make a decision on the basis of the false information Dr. Mires provides to her. Hence, the option of deciding to do what is most likely to contribute to protecting and promoting her health is closed off to her. She can only *believe* she is making that decision, for Dr. Mires has forced her to deliberate on the basis of a false assumption.

When knowledge is power, ignorance is slavery. When Dr. Mires deliberately misinforms Ms. Sligh, he cripples her ability to carry out any plans she might have. It doesn't matter if she decides she doesn't want to have a hysterectomy and so avoids the risks, pain, and expense of surgery. Not only has she been made to worry needlessly and perhaps agonize over her decision, Dr. Mires' deception has put her in a false

position with respect to making decisions about her life. Unknown to her, he has restricted her freedom to make meaningful choices. He has discounted her ability to reason and make decisions, and in this way, he has treated her with disrespect.

Disrespect and the Patient's Good

The most serious cases in which physicians have traditionally considered themselves justified (and perhaps even obligated) to deceive a patient are ones in which the patient is dying and the disease can no longer be treated effectively.[3] In the past, the question was most often one of whether to tell a patient he had cancer. Now that cancer treatments have become more effective, the question has usually become one of whether to tell a patient a treatment is not likely to be effective in extending his life. The central issue remains the same, because the physician must still decide whether to deceive the patient.

Consider the following case. Susan Cruz, a thirty-four-year-old single mother of a six-year-old boy, suffered for more than two months from excruciating headaches that were often accompanied by vomiting and dizziness. Yet it wasn't until after she lost control of the left side of her body and collapsed in the bathroom in what she thought of as a fit that she went to see her HMO doctor. He immediately referred her to Dr. Charles Lambert, a neurologist, who, after a detailed examination, ordered an MRI of her brain. Susan had two seizures in the hospital, right after the scan. She was admitted, and the MRI was followed by a brain biopsy performed by Dr. Clare Williams, a neurosurgeon.

The results of the tests showed Susan had an aggressive form of malignant brain cancer affecting the glial cells. The cancer was so extensive Dr. Williams advised Dr. Lambert that not only was a surgical cure out of the question, surgery to reduce the amount of cancerous tissue would not be worth the risk of additional brain damage. Radiation treatments might shrink some of the tumor, but Susan's disease was so far advanced they would have little effect on the outcome.

After reviewing all the information in Susan's case, Dr. Lambert concluded it was not likely that whatever was done would extend Susan's life to an appreciable extent. Most likely, she would be dead within a few weeks, a month or two at the most. But should he tell her this? Wouldn't it be better to allow her to spend her last days free of the dread and anxiety that knowledge of the imminence of her death was sure to cause her? She and her son, Bryan, could share some time together free from the worst kind of worry. She could do nothing to prevent her death, so shouldn't he leave her feeling hopeful about the future? After all, he couldn't *know* she would die in a few weeks.

"You have a disease of the supporting cells in the brain," Dr. Lambert told Susan. "That's the reason for the headaches, dizziness, vomiting, muscular weakness, and seizures."

"Is there a treatment?" Susan asked. "Will I have to have brain surgery?"

"Not for your stage of the disease," Dr. Lambert said. To avoid explaining why, he quickly added, "Radiation therapy is the best treatment we can offer, because X-rays will help kill off the abnormal tissue putting pressure on your brain."

"Will that make the headaches and all the rest go away?"

"It will help," Dr. Lambert said. "But we have medications that will help also. I can give you steroids to reduce the brain swelling and an anticonvulsant to control your seizures. I can also treat the headaches with effective drugs."

"When do my treatments start?"

"I'll prescribe some drugs today and set you up with the therapeutic radiologists," Dr. Lambert said. "I imagine they can start your treatments in a day or so."

"Great," Susan said. "I've got to get well so I can take care of Bryan. He's staying with my mom, and she's got a heart problem. A six-year-old boy can be a real handful."

Susan followed the treatment plan outlined by Dr. Lambert. She took the drugs prescribed and, with the help of her friend Mandy, showed up at the hospital for her radiation treatments for four weeks. She missed the fifth treatment, because she began having uncontrollable seizures and was taken to the hospital. She died the day after her admission.

Dr. Lambert never told Susan she had brain cancer, nor that the reason surgery wasn't appropriate was that the disease was so far advanced it would be useless. He didn't tell her that, by his estimation, she had only a few weeks of life remaining. Dr. Lambert didn't lie to Susan, but he deceived her. What he told her about her medical condition was vague and limited. He didn't share with her information he possessed that was relevant to her condition. He chose his words so that she would believe she had a disease that might be either cured or controlled by the treatments he prescribed.

While Susan did not (we may suppose) press Dr. Lambert for more information than he provided or ask him questions about her illness, this does not mean Dr. Lambert was not engaged in deception.[4] Susan (like many people) may not have known enough about medicine or her own body to ask the right sort of questions, may have been so intimidated by doctors not to dare to ask questions, or may have been psychologically incapable of asking questions about her illness, preferring to leave everything in the hands of her physician. Dr. Lambert, at the least, should have found out from Susan how much she wanted to know. A willful ignorance is, after all, quite different from an enforced ignorance.

It was also disingenuous for Dr. Lambert to reason that because he cannot be *certain* Susan will die of her disease within a few weeks, he should withhold information from her. Uncertainty of that kind is an ineliminable part of medical practice, and Dr. Lambert has every reason to believe Susan has a relatively short time to live. Judges instructing juries in death penalty cases often distinguish between real doubt and philosophical doubt in explaining the meaning of "reasonable doubt." Dr. Lambert has no real doubt about Susan's fate, and she is entitled to his best medical judgment.

Dr. Lambert's deception of Susan Cruz, like Dr. Mires' deception of Ms. Sligh, is morally wrong. Dr. Lambert deceives Susan with the aim of doing something good for her, while Dr. Mires deceives Ms. Sligh with the aim of doing something good for himself. We might thus say that the deception practiced by Dr. Mires is morally worse than that practiced by Dr. Lambert. Even so, Dr. Lambert's deception of Susan Cruz is still wrong, because it treats her disrespectfully.

By failing to provide Susan with crucial information, Dr. Lambert violates Susan's right to shape what is left of her own life. He deceives her into believing that, with the treatments he prescribes, she can go back to living a normal life and might eventually become healthy again. Because this is not so, Susan is thus denied the opportunity to decide how to spend the final weeks of her life.

She is unable to do what she might prefer to do, if she knew she had a fatal disease and a relatively short time left to live. She might reestablish a connection with her ex-husband, complete the novel she was writing, or visit New York. Most important, she might arrange for someone to take care of her six-year-old son. Prevented by Dr. Lambert's deception from knowing she may soon die, Susan is barred from pursuing what she values most in the time she has remaining.

Respect for persons bars the deception of patients. When the deception is for the physician's benefit, the wrong is obvious. Yet even when the deception is intended to benefit the patient, the physician's good intention doesn't alter the fact that the deception violates the patient's autonomy.

Three Critical Questions

Three questions about physicians' telling the truth to their patients arise with sufficient frequency as to warrant their being addressed explicitly.

1. What if a Patient Doesn't Want to Know About His Disease or the State of His Health?

Some writers have argued that many patients don't want to know what's wrong with them.[5] Although they may say they do, some don't mean it. Part of the physician's job is to assess how much information and what sort a patient can handle, then provide him with an appropriate amount and kind. Thus, a physician may decide that a man in his mid-thirties doesn't want to know he is showing the first symptoms of (say) Huntington's disease. Although the disease is invariably fatal and essentially untreatable, it is slow acting, and the patient may have another ten or fifteen years of more-or-less normal life before the worst symptoms of the disease manifest themselves. The physician may decide to spare the patient the anguish of living with the knowledge that he is eventually going to develop a fatal and particularly nasty disease. The patient, she judges, really wants

her to protect him from the years of agony and uncertainty.

But with no more than her own assessment to guide her, in making judgments about what a patient wants to know, the physician is taking too much on herself. Huntington's disease is a genetic disorder that occurs when a parent passes on the HD gene to a child. Someone with one parent who has HD may already know he has a fifty-fifty chance of developing the disorder. He may want to know whether the problems he is experiencing are symptoms of the disease. If they are, he may choose to live his life in a way very different than he might if the problems are not symptoms. He might decide, for example, not to have a child and to avoid the risk of passing on the gene for the disease. Or if he and his partner decide to have a child, they might opt for artificial insemination and embryo screening to eliminate embryos carrying the HD gene. The physician is generally in no position to decide what information needs to be withheld from a patient. Full disclosure should be the default position for physicians.

The Patient Is Explicit. If a patient clearly and explicitly expresses the wish not to know the truth about his medical condition physicians should generally respect this desire. No disrespect is involved in not telling the truth (not providing information) to someone who decides he does not want to know it. The ignorance he imposes on himself may be necessary for him to go on with his life in the way he wishes.

Thus, someone may know himself well enough to realize that if he were diagnosed with inoperable cancer, he wouldn't be able to think about anything else, and the remainder of his life would be a misery of anxiety and fear. His physician should respect such a wish to remain ignorant, for it is as much an expression of autonomy as is the wish to be informed.

When a patient expresses the desire not to be informed about his medical condition, this does not justify his physician's *deceiving* him about his condition. The physician is warranted in withholding the truth from a patient who has asked to be kept ignorant, but the physician is not warranted in telling the patient nothing is wrong with him when there is or falsely assuring him he doesn't have metastatic prostate cancer.

Overriding Considerations? Cases in which patients do not wish to know about their medical condition may not be as rare as they once were. Some patients don't want to know if they are infected with HIV, for example, and request that they not be informed of test results that might show they are HIV-positive.

Such cases raise the question of whether the respect for persons that grounds the physician's obligation to allow a patient to make his own decisions requires the physician always to be bound by a patient's explicit wish not to be informed about his medical condition. We think not.

Where HIV or some other contagious disease is involved, the patient has a need to know, not necessarily for his own sake, but for the sake of others. Those who do not want to know they are HIV-positive lack information crucial to decisions concerning their own behavior with respect to others. The physician has an obligation to a particular patient, but she also has an obligation to prevent harm to others who may come into contact with that patient. Failing to tell a patient he is HIV-positive, even if he has requested not to know, makes her complicitous in the spread of the disease. She is not responsible for her patient's actions, but she is responsible for making sure he has information relevant to decisions affecting others. Violating his autonomy to the extent needed to inform him is justified by the possibility that it may save the lives of others. (If she discovered an airline pilot suffered from a seizure disorder, it would be morally wrong for her not to make sure the airline was informed.)

A question similar to that about infectious diseases arises about the "vertical transmission" of genetic diseases. Suppose a thirty-four-year-old man whose mother died of Huntington's doesn't want to be tested to find out whether he is carrying the gene (and so will develop the disease). He is bothered by some movement problems and episodes of mental confusion. He wants his physician to treat him for these but not tell him whether they are symptoms of the onset of Huntington's. The man is about to be married, and he has told his physician he and his wife intend to have children.

After examination and testing, the physician believes the patient's problems are symptoms of HD and are likely to get progressively worse. Moreover,

the physician knows that offspring of the man have a fifty percent chance of inheriting the gene that causes the disease. Should the physician go against the patient's explicit request and inform him it is likely he has HD?

Once again, violating a patient's autonomy to the extent of telling him something he does not want to hear seems warranted. If the patient knows he may have HD, he might decide either not to have children or to employ embryo screening to avoid having a child that inherits the HD gene. In the absence of this knowledge, he may be more likely to have a child who will inherit the gene and eventually develop a painful, lingering, and fatal disease. Decreasing the likelihood of bringing a child into the world who will eventually develop such a disease justifies the physician's going against her patient's wishes. (Before reaching this stage, the physician might talk to the patient and attempt to get him to change his mind by telling him what might be at stake and making sure he understands his reproductive options.)

In summary, we hold that while a physician has a prima facie obligation to withhold the truth about a patient's condition from the patient at the patient's request, in some circumstances the physician may have a duty to ignore the request and provide the patient with information he doesn't want to hear.

Patients Who Don't Say. What about patients like Susan Cruz who express neither a desire to be fully informed nor a wish to be kept ignorant? Physicians are justified in presuming that patients want to know about the state of their health, diseases they may have, and the appropriate treatments for them. This presumption is no less than the recognition that patients are persons, that they are rational agents who may be assumed to want to make informed decisions about matters affecting their lives. Setting aside this prior presumption requires that a patient explicitly inform a physician that he or she wishes to remain in ignorance. Informing patients about their medical condition is, again, the default position for physicians.

Further, if a physician has doubts about whether a patient wants to be informed about her medical condition (as we discussed earlier in connection with Susan Cruz), he should make an effort to determine at the beginning of the relationship whether the patient wants to know about the nature and seriousness of her disease. "Don't ask, don't tell" is by no means an appropriate model for physician-patient communication, and because the physician holds the stronger position in the relationship, it is up to him to find out about how much his patient wants to know.

Studies indicate that a significant majority of patients do want to know about the state of their health. In most studies, over eighty percent of patients surveyed reported that they would want to be informed if they were diagnosed with cancer or some other serious disease.[6] Thus, telling a patient the truth can be regarded as the default position for the physician on grounds that are empirical as well as moral.

2. What if a Physician Is Unable to Tell a Patient the Truth?

Physicians cannot tell patients what they don't know themselves. Nothing is wrong with a physician's admitting that little is known about the patient's disease or that the patient's symptoms don't point to a clear diagnosis. Patients are aware that physicians aren't omniscient, and a physician who confesses to ignorance or puzzlement may be showing respect for the patient. A physician must recognize his own limitations, as distinct from the limitations of the state of medicine, and be prepared to refer a patient to someone more able to address the patient's problem.

Actual ignorance and the consequent impossibility of telling a patient the truth is not the issue that physicians and patients typically focus on in the conflict over truth-telling. The issue is usually about whether physicians, when they know the truth, are able to tell it to their patients.

A complaint often expressed by physicians about the need to get a patient's informed consent before carrying out a surgical procedure is that patients are unable to understand their explanations. The notion underlying this complaint is that, even when physicians try, it is impossible to inform patients about their medical condition.

This notion lies at the base of the argument that physicians, even when they do their best, cannot tell their patients the truth. Patients (the argument goes) lack the technical background and experience of

physicians, so even intelligent and educated patients are not able to understand the medical terms and concepts physicians must use to describe a patient's condition. Physicians, if they are to communicate at all with the patient, must then switch to using terms and concepts that neither adequately nor accurately convey to the patient what is wrong with him. Thus, it is impossible for physicians to tell patients the truth.

Critics have pointed out that this argument that physicians are not able even in principle to tell patients "the truth" rests on a confusion between "whole truth" and "wholly true." Physicians, we can agree, cannot tell patients the "whole truth," meaning that no patient is going to be able to understand all the known details of a disease process as it affects him. Medicine is an information-rich enterprise, and even physicians are quickly out of their depth in areas beyond their expertise. How many of us really understand the pancreas?

Even so, the explanation of a complicated situation in ways a layperson can understand is not a challenge unique to physicians. The same problem is faced by lawyers, electricians, automobile mechanics, and computer help-line workers. In none of these fields, including medicine, is it necessary to provide the layperson with a complete explanation (the "complete truth") of a situation. All a patient requires is an understanding adequate to appreciate the nature and seriousness of his illness and the potential benefits and risks of the available therapies. A diabetic need not know the stages of oxidative phosphorylation to grasp the importance of insulin and role of diet in maintaining her health.

The argument also does not support the claim endorsed by some writers that, because a physician cannot tell their patients "the truth" (the "whole truth"), it's all right to tell them what is not "wholly true"—that is, to deceive them. Such deception may involve using vague language to explain a patient's medical condition. Thus, Dr. Lambert tells Susan Cruz, "You have a disease of the supporting cells in the brain," when he should have explained to her that she had a particular kind of brain cancer, one that was aggressive and that had advanced to an inoperable stage. The view that the impossibility of telling a patient "the whole truth" makes it all right to tell the patient something not wholly true is analogous to saying, "Because I can't pay you the money I owe you, it's okay for me to rob you." Not being able to tell "the truth" is not a license to deceive.

Respect for persons requires that physicians tell their patients the relevant facts about their medical condition in a comprehensible way. It doesn't require trying to tell patients all the facts. Telling the truth is no more an impossibility for physicians than it is for automobile mechanics.

3. Don't Physicians Sometimes Have a Duty to Lie to Their Patients?

Some writers have argued that respect for persons and their autonomy sometimes permits physicians to deliberately deceive their patients. Granting that a sick patient desires to regain his health, then if that desire can most likely be attained by his physician's deceiving him, the physician is justified in carrying out the deception.[7] Deceiving the patient in such a case assists him in securing his goal, so a respect for the patient's goal makes the deception permissible. The physician violates the patient's autonomy a little while the patient is sick so that he will regain his health.

This is not a view that can be dismissed as obviously flawed, but it is one we ought to be cautious about adopting without qualification.

First, it is easy to overestimate the extent to which lying to a patient will be useful in helping him regain his health. We certainly don't have any data that show the relative advantage of deceiving patients about their illnesses. The old notion that if a patient with a serious illness is protected from anxiety and worry about his condition, he will heal faster is no more than speculation. As such, it will not justify our infringing someone's autonomy for the sake of what is at best a hypothetical gain.

Second, it is easy to underestimate the benefits of informing patients about the character of disease and the aim of the treatment. Most treatments for serious diseases require the full cooperation of the patient. A woman diagnosed with metastatic breast cancer must go through a rigorous course of therapy, ranging from surgery through chemotherapy and radiation treatments. If she knows that her cancer has spread from the breast to other places in her body and knows her chances of survival, she is more likely to adhere to the treatment plan mapped out by her oncologist. Deceiving the patient about her medical problem is probably, in most cases, more likely to work against her goal of preserving her life and regaining her health. Thus, deception may not only violate her autonomy, it may contribute to the loss of her life.

Let us suppose, however, that in some cases we can know with reasonable certainty that if we deceive someone about her illness this will contribute to her recovery. Is it acceptable to use deception and violate autonomy in the short run, if the deception can be expected to promote autonomy in the longer run?

Recalling an example mentioned earlier should make us wary of answering this question in the affirmative. It would be wrong, we said, to kill one healthy person to obtain organs to save the lives of four people. Such examples suggest it is wrong to interfere with autonomy (that of the healthy person) for the sake of promoting autonomy (that of the four sick ones).

Yet we generally agree it is acceptable for the federal government to tax people with a certain income, then use part of the money to help feed starving foreigners. This suggests it is *not* wrong to interfere with autonomy (that of taxpayers) to promote autonomy (that of the starving). Are our responses in these two cases inconsistent, or is there a difference between the cases? We suggest there is a difference.

In both cases, the gain in autonomy is great (lives saved), but in the tax case, the infringement of autonomy needed to achieve a great gain is minor. Taxing us as citizens takes away some of our resources and thus counts as an infringement of our autonomy. Yet we still retain a substantial degree of control over the important parts of our lives.

The contrast between these two cases suggests the following principle: It does not show a disrespect for persons to violate their autonomy, if the violation is minor and the potential gain is both probable and significant. Thus, for example, if a physician is confident she can save a patient's life by deceiving him for a short while, it is not wrong for her to deceive him. Suppose Ms. Cohen has an irrational fear of taking antibiotics, yet if she is not treated for a bacterial lung infection, she will, almost certainly die. Her physician, in such circumstances, would be justified in telling her something like, "The pills I'm giving you will help your body fight the infection."

Such cases are sure to be rare, however. In most cases, either the stakes will not be high enough (someone's life) to justify deception or deception will not be likely to help. Most often, the physician's only legitimate course is to respect her patient's status as an autonomous agent. This means not trying to deceive him and helping him make decisions by providing him with information relevant to his disease and the treatment options open to him.

Conclusion

We have argued that a principle of respect for persons requires that physicians not engage in deceiving patients. It is clearly wrong for physicians to tell patients they need surgery that they don't need. Such a lie is wrong, we have contended, because it prevents patients from making informed choices about their lives. This is also true of deception intended to benefit a patient. In all but the rarest cases, deceiving a patient "for his own good" is an unacceptable way for physicians to try to help their patients.

NOTES

1. Mark Lipkin, *Newsweek* (June 4, 1979), p. 13. See also Joseph Ellin, "Lying and Deception: The Solution to a Dilemma in Medical Ethics," *Westminster Institute Review* (May 1981), pp. 3–6, and Joseph Collins, "Should Doctors Tell the Truth?" in Samuel Gorovitz *et al.*, eds., *Moral Problems in Medicine*, 2nd ed (New York: Prentice-Hall, 1983), pp. 190–201.
2. Immanuel Kant was the first to articulate this idea. See his *Groundwork of the Metaphysic of Morals*, tr. H. Paton (New York: Harper Torchbooks, 1964), esp. p. 96.
3. Lipkin, *loc. cit.*
4. Sissela Bok, *Lying: Moral Choice in Public and Private Life* (New York: Pantheon Books, 1978), p. 229.
5. Lipkin, *loc. cit.* See also Lawrence Henderson, "Physician and Patient as a Social System," *New England Journal of Medicine* (1955), p. 212.
6. Bok, p. 227.
7. Jane Zembaty, "A Limited Defense of Paternalism in Medicine," *Proceedings of the 13th Conference on Value Inquiry: The Life Sciences and Human Values* (Geneseo, NY: State University of New York, 1979), pp. 145–158. See also Terence Ackerman, "Why Doctors Should Intervene," *Hastings Center Report* (August 1982), pp. 14–17.