The Truth, the Whole Truth, and Nothing but the Truth: Therapeutic Privilege

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Case Report

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Abstract

The term therapeutic privilege is unfamiliar in the medical field and often sparks questions and discomfort about its ethical implications. Therapeutic privilege refers to the act of withholding of information by a clinician, with the underlying notion that the disclosure of this information would inflict harm or suffering upon the patient1. This is a case of a 56-year-old woman who presented to our facility in critical condition: sepsis with acute respiratory failure requiring intubation and mechanical ventilation. Prior to her admission, her husband had been admitted at our facility and was being cared for in the intensive care unit. On the same day that our patient was extubated, her husband had died. The palliative care team was consulted to assist with disclosing this information to the patient in light of her emotional fragility, her anxiety and concerns for her ability to receive such news given her own active illnesses.

Background

Therapeutic exception or therapeutic privilege is defined as the withholding of relevant health information from a patient if nondisclosure is believed to be in his or her best interest (1–3). It is an exception to the general rule of informed consent and only applies when disclosure of the information itself could pose serious and immediate harm to a patient (1–3). Withholding medical information from a patient without their knowledge or consent is generally ethically unacceptable; however, under certain circumstances, therapeutic privilege can be utilized (2). Physicians should encourage patients to specify their preferences regarding communication of their medical information, including their preferences about treatment and goals of care, ahead of time to avoid confusion when they are unable to communicate their wishes (2). We describe a case at our institution in which the therapeutic exception was argued and used to withhold information from a patient in the intensive care unit. The information being withheld was the news of the death of her husband. In medical practice, interventions require that a physician obtain informed consent, be it for any procedure or treatment, unless sufficient grounds of justification exist, such as necessity, authorization by the court, waiver, or a therapeutic exception (4). If the consent is not attainable from the patient or they wish not to know about their medical condition, then the next of kin will be asked to consent or to make decisions on behalf of the patient. Therapeutic privilege is a well recognized, but rarely if ever used, exception to informed consent. A health care professional may withhold information from a patient with regards to a diagnosis or the nature of a proposed treatment and the risks involved when the provider believes that disclosure of the severity of the condition or the drastic nature of the treatment indicated could be therapeutically detrimental to such a degree that his/her recovery may be compromised4. Internationally, therapeutic privilege is accepted in many jurisdictions, including England and Wales, Netherlands, Australia and Canada (5). The American Medical Association’s Code of Medical Ethics states that physicians may withhold information (i.e. when the patient is unconscious, and when the benefit of treating the patient outweighs the harm) about a patient's diagnosis or treatment when disclosing it would pose a serious psychological threat, so serious a threat as to be medically contraindicated. The concept of no harm needs to be justified appropriately when therapeutic privilege is

used. As knowledge is a powerful tool, keeping it away from patients can put the physician in an ethical and legal predicament (6).

Case Description

Our patient was a 56-year-old woman, with medical conditions including class 4 Heart Failure with reduced ejection fraction, Diabetes Mellitus, Hypertension, and Obstructive Sleep Apnea, who presented to our institution via the emergency department, brought in by emergency medical services for evaluation of acute delirium. She was found to be positive for influenza and started on treatment. At the time of initial presentation, our patient voiced feelings of sadness and depression, explaining she felt this way since her husband had been admitted to our intensive care unit for sepsis. It was after discussion was held with patient's family members that it became apparent: not only was she suffering from feelings of depression, but she also had become withdrawn from others and had stopped taking her routine medications for her comorbid conditions since her husband was hospitalized. Our patient was treated for sepsis in the setting of pneumonia, influenza and was restarted on appropriate heart failure and diabetes treatments. Her condition deteriorated, and she was intubated for acute hypercapnic respiratory failure, at which time she was transferred to the intensive care unit for further medical management (where her husband was also being treated).

On her eighth hospital day, she was medically extubated. On this same day, her husband had deteriorated and died. The palliative care team was consulted to assist with breaking bad news to her. A family meeting was first held with her children and extended family members to discuss how to best reveal this information. There was concern from her family members, as well as the intensive care team, that having just been extubated, she may be too physically and emotionally frail to receive the news. Our concern was if she heard that he had died, she may decompensate medically, requiring reintubation and further ventilator support. It was in fact her children who requested that the therapeutic privilege be utilized and that physicians withhold the information about her husband's death. This case was reviewed with our hospital's Ethics Committee, who were supportive of utilization of a therapeutic exception to withhold this information from her at the request of her family members.

The patient was fragile, exhibiting ICU-related delirium and tenuous respiratory status requiring frequent non-invasive ventilatory support. She frequently told staff and family members she was 'seeing and hearing' her husband while she was being treated in the intensive care unit after the time of his death. On her eleventh hospital day, a meeting was held with family members, and the decision was made to pursue explaining to the patient that her husband had died 3 days prior. Members of our palliative care team, as well as the intensive care team and family, were present when patient was informed of her husband's death. She was upset and grieving when she received the news.

Discussion

This case highlights the ethical use of nondisclosure from both the palliative care and intensive care teams. Non-disclosure (of our patient's husband's death) was justified as a therapeutic exception. Which "allows the physician to withhold information from a patient if that information would psychologically harm the patient and thus imperil the patient's physical health" (6). From the time our patient was admitted to the hospital, growing concerns developed from both the palliative care and intensive care teams of how medical decision-making would be addressed. Neither our patient nor her husband had a written advanced directive. After discussion with their family members, it was also clear that neither patient had verbally addressed advanced directives with them prior to this hospitalization. Ideally, our patient would serve as her husband's surrogate and visa versa, but they were both incapable of doing so in this situation. It was their children (with input from extended family members) who provided consents for interventions and therapies as the legal surrogates for decision-making, in accordance with the Family Health Care Decisions Act. They opted to pursue all life sustaining therapies for both parents, thankfully, as this eased any provider discomfort and conflict that would otherwise arise (e.g. if they had elected to forego any interventions for either parent).

The Ethics Committee was informally consulted prior to implementing the therapeutic privilege. The argument provided in support of its use by the Ethics Committee was that 1) withholding of this information was a request initiated by her own family members; 2) this was a notably emotionally and physically frail patient (i.e. she presented with decreasing functionality for activities of daily living while her husband was admitted, had declining performance status, and had stopped taking even basic medications for her own health conditions); 3) once the patient was deemed stable enough to receive the news, rapid disclosure would be made to inform her that her husband had died; and 4) there was no imminent decision-making that would require disclosure for her to provide informed consent (e.g. acute needs for disclosure to proceed with consent for autopsy or funeral planning).

This case is an example of the use of deception by not disclosing the husband's death to the patient immediately after extubation. In the medical profession, deception is considered wrong. Some consider withholding information the moral equivalent of lying (6). In our case, we did not disclose sensitive information to the patient about her husband's death, and when she asked about her husband, we deferred answering those questions. We did not directly lie to the patient (i.e. we did not tell her he was still alive), but we did not disclose the truth of the events that had occurred. There are two different opinions in literature, one stating that there is a moral distinction between lying and deception and second that favors them equal (3). Both opinions have defenses. Some regard deception as dishonest and morally equivalent to lying if not even worse, because it creates a false belief (3), and with deception, the physician my loose their focus of his/her real intentions in the patient care process. A summary of opinions across academia generally conclude that all lying and all deception (verbal or nonverbal) are equal and wrong when used in medicine, as these practices endanger trust, break rapport, and are unethical and disrespectful (7). We believe that while maintaining cognition of the ethical implications of non-disclosure, we were justified in withholding this information based on the medical principle of Primum Non Nocere (First, do no harm). Our reasoning for non-disclosure in this particular case is that the delay in informing the wife was brief and limited to a short state while she herself was recovering. Our

disclosure was rapid, done after a withholding period of three days. Withholding was done at the surrogate's request, and there were no actions of decision making required during the period of non-disclosure. As stated, we wanted to allow the patient to come to terms with the events, both physically and emotionally, especially after she had demonstrated both depressive symptoms and delirium. A physician must always weigh beneficence against non-maleficence, balancing benefit against avoiding potential harms, putting into perspective both the benefit and the potential harm that may be caused. A potential justification for modifying the truth is that it is likely to produce a greater advantage for the patient and less harm, bearing in mind that harm includes direct trauma, anger, feelings of betrayal and loss of trust in the healthcare system (6). We discussed our decision with the family who preferred the delay to break the news and supported our judgment of when and how to disclose. Our patient was informed about her husband's death three days later in the presence of family members. She cried, and she was upset for the loss of her lifelong companion, which are appropriate reactions of grief. She exhibited great self-awareness of her psychological instability whilst her husband was initially admitted. She acknowledged her feelings of depression, her withdrawn behavior, and that she had stopped caring for herself in his absence. As she acknowledged her own frailty, she agreed with the request (made by her family members) to withhold this information and the rationale of waiting to disclose the information sooner. This is a unique case where we were challenged in balancing the necessity to inform the patient (principle of autonomy) and the desire to ensure the patient's wellbeing by minimizing suffering (principle of nonmaleficence).

Rationale Of Therapeutic Privilege

In the United States, withholding medical information from patients without their knowledge or consent is ethically unacceptable (8). Non-disclosure poses the risk of tarnishing the doctor-patient relationship as well as the risk of losing rapport and trust; however, in select, unique situations, the medical relationship may require that the doctor consider the limits of the therapeutic processes, the circumstances, and the limitations of an individual patient (9). The courts have noted two additional exceptions to informed consent (8). The first pertains when both the patient is unconscious or otherwise incapable of consenting and when the benefit of treating the patient outweighs the harm of the treatment. Under these circumstances, one can argue that the physician is not required to obtain informed consent before treating, but must do so as soon as it is medically possible (8). Examples include when a patient requests not to be told about their cancer diagnosis to preserve mental health, or about the prognosis of their illness to keep hope, as these will put the physician in a situation that requires balance between the truth and deception. However, we believe that telling the truth is always the right thing to do.

Physicians are encouraged to consult with colleagues and hospital Ethics Committees if even considering withholding medical information from their patients. We suggest taking into consideration not only the sensitivity of the information that is being considered for withholding, but also the urgency of the clinical situation and the nature, seriousness, and reliability of the information that is being withheld. In the future, we don't advise to use the same approach, as it was difficult to hold the information from

the patient by involving all the parties that participated in patient care. In our situation, the therapeutic privilege was used only temporarily for a few days and retracted when the patient was medically stable.

Conclusion

There is extensive literature challenging whether it is ever ethically appropriate to invoke a therapeutic privilege. The focus has been the tension between respecting a patient's autonomy and protecting a patient from harm when the physician perceives that the patient might have difficulty processing information. Given these significant potential harms and the moral duty to tell the truth, the justification for nondisclosure must be extremely compelling, as it was in our case.

Declarations

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A statement on participant consent: Verbal informed consent was obtained from the surviving patient for publication of this case report and the events discussed.

Competing interests: The authors declare no competing interests

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