must be excluded from the physician's judgment if he follows the principle of doing what he thinks will benefit his patient, those familial consequences certainly are not irrelevant to Mr. Crossman's own moral decision-making. He has an obligation to provide for his family and presumably an interest in their welfare as well. From the standpoint of consequences it seems that he has a strong obligation to have the important information about his future.

What, however, if there were no family members in the picture? Would there then be any obligation to accept the information if he would rather not be troubled with it? While the freedom of choice of the competent patient might justify his right to refuse the information, some would nevertheless hold that such refusal is still not ethically the best course. According to this view, a mature adult has an obligation as well as a right to make decisions about his own medical care. The fact that avoiding unpleasant information makes life more comfortable would not necessarily make it right. Some would make the case that Mr. Crossman ought not to have requested the nondisclosure even if the interests of his children were excluded from the case.

Family Members Who Insist the Patient Not Be Told

A second kind of special case involves a patient whose family insists the patient should not be told or that the consequences of telling would be so bad that the physician should refrain. Now it is the family member who is claiming the authority to waive the right to know. In some cases, such as the two that follow, it can be argued that the patient would be hurt, psychologically or physically, if he or she knew the threatening information. Some families might also be concerned that the patient could not understand the information, that he or she might really not want to know, or that the patient would be better off not knowing. Nevertheless, the question persists whether there is anyone who has the authority to overturn the patient's claim on the information. The first of the cases in this section involves a patient from a culture where nondisclosure is the norm. In this case, there is no reason to believe that the patient is mentally impaired and, in the United States, nondisclosure would appear to constitute treating without consent. In the second case, the patient may well not be mentally competent, in which case the next-of-kin is normally the presumed surrogate. The issue becomes one of whether the valid surrogate can decide that the patient should not be informed.

CASE 7–6

A Clash of Cultures: A Japanese Family Asks that Their Father Not Be Told of Cancer

The surgeon, Dr. Phyllis Rollins, had just examined the patient after referral from an internist. Dr. Rollins was part of a large oncology practice in a large West Coast

American city. Mr. Nikki previously had endoscopy and biopsy of the stomach confirming a very large cancer. Since Mr. Nikki spoke little English, his son came into the room to help. The patient's wife took the patient into another room beyond hearing distance. Then the surgeon fully explained the nature of the malignancy, that operation is clearly indicated, and that the father must be given that information, including the process of preparation, the prognosis, the risks, probable outcomes, and other details so that truly informed consent may be obtained. Abruptly, the son replied that if his father were told the diagnosis, "he will wither up and die." Dr. Rollins replied that she cannot proceed with surgical care of Mr. Nikki without his understanding of and agreement to a major operation. "You just don't understand 'the Japanese way'—in Japan, the word 'cancer' cannot be mentioned," said the son. He proposed that Dr. Rollins tell Mr. Nikki nothing, and prepare for surgical treatment secretly. Dr. Rollins withdrew from the case, providing some other surgeons' names to the family. Later, she learned that the patient had been operated upon at another hospital, presumably without being told of his diagnosis.

COMMENTARY

Given the facts as presented, the initial surgeon felt bound by important ethical principles and the law requiring that patients be told truthfully of their condition as part of the consent process. Failure to disclose would mean that consent is not adequately informed, which would constitute an assault against the patient. In this case, Dr. Rollins withdrew from the care of the patient by referral. The net result was that, as far as Dr. Rollins knew, the patient was treated without being fully informed.

It could be claimed that Mr. Nikki delegated decision-making authority to his family, who aggressively acted for him in their understanding of his best interest. He could have done so explicitly (although there is no evidence of this). Some patients, particularly those in stressful medical situations, may explicitly acknowledge that they do not feel capable of handling decision-making and may waive their right to be informed. That was the issue in the previous case.

This case presents a more complicated problem. Assuming that Mr. Nikki did not explicitly waive his right to be informed and consent to his medical treatment, could it be argued that, given that he was part of the traditional Japanese culture in which disclosure to the family rather than to the patient was the usual custom?[15]

There are problems with the presumption that Mr. Nikki would consent to having his family take over decision-making. Even in Japan there are people who reject the traditional view. They insist that they would want to be informed of their diagnosis and retain decision-making authority. Since there is no way to determine whether a specific patient is in this group who would want to retain his or her decision-making authority (and patients cannot be asked without arising suspicion of some serious medical problem), showing respect for the unidentified group who are not willing to let their family play this role is a serious problem in Japan. From the point of view of those who believe there is a moral right to truthful disclosure, this right cannot be waived by majority vote even if it can be shown that the patient is from a culture that generally follows a pattern of nondisclosure.

In the United States, the issue is even more complicated. There is an increasing moral consensus in favor of truthful disclosure of diagnosis. The duty of honesty is even incorporated into the AMA *Code of Ethics*. Hence in the United States, where Mr. Nikki is being treated, both law and ethical principle support a duty of disclosure. Although that duty might be overridden in the case in which a competent patient explicitly authorizes nondisclosure, it is hard to imagine the justification based solely on the instruction of the family.

The physician who accepted the case under the reported "don't tell" stipulations of the Japanese culture did so even though there was no evidence that the patient was incompetent. Postoperative care might well be compromised by complications, need for reoperation and/or intensive care, and so on.

The issue of familial request for nondisclosure is even more complex in the case in which there is doubt about the mental competency of the patient. That is the situation in the next case.

CASE 7–7

Disclosing Cancer to a Mentally Compromised Patient

A 64-year-old man, David Younis, was brought to the emergency room (ER) after his wife found him suddenly disoriented and incoherent. Mr. Younis was known at the hospital for alcohol dependence, with cirrhosis of the liver. Examination revealed liver enlargement including a mass (CT scan). He was admitted to the hospital and a biopsy of the mass was scheduled. Mr. Younis's mental status improved; his wife requested that he not be told if the diagnosis is malignant. Mrs. Younis said that if he learns he has cancer, he will kill himself. Dr. Andre Caldarone, the hepatologist (liver specialist), then cancels the biopsy procedure.

COMMENTARY

This case resembles Case 7-6 in many ways. Both cases involve family requesting that a patient not be told of a diagnosis on grounds that it would be contrary to the best interest of the patient to disclose. The present case differs, however, not only because the potential harm to the patient appears more severe—a purported risk of suicide—but also because that patient has been disoriented and incoherent. The moral principle of veracity and its related notion of informed consent clearly applies to patients who are mentally competent. Whether it also applies to mentally compromised patients is difficult to determine.