Deceiving third parties

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Most discussions of lying or deceiving in the medical ethics literature concern health care workers lying to patients. There is little discussion of cases in which medical professionals are faced with a decision about whether to lie to third parties on a patient's behalf, although such cases are fairly common; cases in which general practitioners and other health care workers must decide whether to deceive parents, partners, insurers or agencies charged with providing benefits to patients, or perhaps even other health care professionals. Not only are such cases common, but thinking about them might tell us something about honesty in medicine more generally.

Imagine an apparently easy case. A mother brings her 15-year-old daughter to see you. You think the girl might be pregnant, but everything the mother says suggests she thinks that can't be possible for the most obvious reason, and the daughter isn't saying anything. You could tackle the issue directly and honestly—simply asking the daughter and telling the mother you need to exclude the possibility—but you might judge that that would be unhelpful. You fear the girl will lie if put on the spot, or that a blunt approach will provoke an unhelpful and ill-timed confrontation between the pair. You could seek a urine sample and do a pregnancy test, but you think the mother would realise what you were considering, and you'd need some (perhaps deceptive) story for the daughter. Or you could tell the mother that you need to take the daughter into another part of the clinic to weigh her, aiming in fact to get the daughter alone so you can ask her what she's been up to.

I suspect many general practitioners would take the third option, even though it involves deceiving the mother (and the daughter albeit briefly), and it's easy to see why. The deceit is relatively minor. It might seem to be 'passing', in the sense that, subject to the daughter's consent, the mother can be brought into the discussion easily enough if the daughter is pregnant (the case will quickly become more complicated if she is and doesn't want the mother to find out). Furthermore, your primary clinical relationship is with the daughter, and a wide range of her interests—some directly medical, some social (her relationship with her mother for instance), and some specific to her clinical relationship with the practitioner (her right to confidentiality, for instance)—seem to support the subterfuge.

As an aside, these last remarks may seem to touch upon an ethical challenge some commentators have suggested is particularly striking in general practice.[1] When patients present at secondary or tertiary care centres, their health interests are typically striking and dominant. Physicians working in those contexts may more easily be able to identify and focus on those interests. In general practice it is more common for doctors to be called upon to manage health interests in conjunction with other competing interests, of the sort raised by the simple case.

The simple case highlights the significance of the standard practice of grounding the value of honesty in patient autonomy, rather than regarding honesty as morally valuable in its own right, or grounding it in autonomy more generally. Kant illustrates the alternatives, famously defending honesty as a categorical value, never outweighed by competing values ('...can necessity ever justify a lie? No! There is not a single conceivable case in which it is excusable.'),[2] and grounded in the centrality of autonomy as a component of moral agency. Deceit is wrong, on Kant's account, because it involves a failure to respect the moral worth of those we deceive. He would not allow us to privilege the autonomy of the daughter over that of the mother—they are equally moral agents—or to allow the value of autonomy, and so honesty, to be outweighed by some competing value. I do not intend to defend Kant's approach—unsurprisingly it is (a little) more nuanced than this quick sketch allows[3]—merely to note the effect of grounding the value of honesty in medicine in patient autonomy. When

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The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

THIS ISSUE: This issue our guest ethicist Associate Professor Tim Dare explores ethical dilemmas around lying or deceiving third parties on a patient's behalf.

medical ethicists talk about autonomy they mean the autonomy of patients, rather than the autonomy of others, and sometimes—perhaps in this simple case—protecting the daughter's autonomy may warrant less concern for the autonomy of the mother.

It might seem that the simple case is simple because the physician has a duty of confidentiality to the daughter. But some care is needed here. Prima facie confidentiality requires silence, not deceit. Even Kant allows the distinction: '...even if everything one says is necessarily true, there is no duty to utter all truths publicly'.[4] Of course, the two may come to the same thing: some silences are informative. (As another aside, that is a reason to think about these matters in advance: the situation would be more straightforward if the doctor had said to the mother and daughter much earlier—when the discussion need carry no particular import—that, while she was happy to have them both as patients, it would best if she saw them separately in order to preserve patient confidentiality). The upshot is that one cannot derive a justification for deceit directly from a right to confidentiality. It needs to be shown at least that one cannot maintain confidentiality without the additional wrong of the deceit, and that the duty of confidentiality warrants that additional wrong.

The simple case also draws attention to the extent to which professional obligations are 'role-differentiated'. Some might think that it is always alright to deceive people provided the consequences of doing so outweigh the moral cost of the deceit. That would be a radical conclusion: we would need to treat all purported statements of truth with suspicion. More plausibly, deceit is almost always wrong by the rights of 'ordinary morality', but some roles bring with them role-specific obligations and permissions which permit and occasionally require role-occupants to depart from the demands of ordinary morality. There are things that health care workers are required and permitted to do because of the role they occupy, which they would not be permitted or required to do outside their role (maintaining confidentiality in circumstances in which a lay person would be morally obliged to inform others is an example). Now the suggestion is that health care workers might have distinct role-differentiated obligations to deceive third parties when doing so is required to serve important goals.

Imagine another case. A pregnant woman and her partner come to see you late on a Friday. The partner waits in the waiting room. It quickly becomes clear that the woman is terrified of her partner, who she explains is abusive and deeply opposed to the pregnancy. She does not want to go home for the weekend. You try to find a room in a shelter, but without success. You decide to have the women admitted to the local hospital overnight, while you find a more permanent arrangement. After carefully considering alternatives, you agree to tell the partner that the woman has a urinary tract infection and, given the pregnancy, requires admission at least overnight. Do you do anything wrong when you pass this misinformation to the partner? (This might be a case in which silence will not do, perhaps creating more and serious difficulties for the patient). I am inclined to think not. The patient has an important interest—we might call it a right—to be free from the threat posed by her partner. If the only way to for the doctor to ensure she enjoys that right is to lie to the partner, then the doctor might have at least a permission (perhaps even an obligation?) to do so.

We might add a wrinkle to this case: should the general practitioner tell the admitting hospital what she is up to? If she does not, then it seems she must mislead other third parties on the patient's behalf, viz. her fellow professionals. Interestingly this is one class of third party deceit which has been the subject of research. The results are sobering: A survey of 330 US internal medicine residents showed that many would deceive a colleague—36% indicated they were likely to use deception to avoid swapping shifts; 15% would misrepresent a diagnosis in a medical record to protect patient privacy; 14% would fabricate a laboratory value to an attending physician; 6% would substitute their own urine in a drug test to protect a colleague; and 5% would lie about checking a patient's stool for blood to cover up a medical mistake.[5] However, lying to colleagues seems especially problematic. In addition to concerns about trust and future dealings, one might think that if the doctor considering deceit in the abusive partner case is right about the options, then she ought to be able to convince her colleagues to cooperate. Describing the situation and the plan to fellow professionals might be a good way of checking that one has indeed thought through the issues and considered all the alternatives.

Consider another case. Your patient has an inguinal hernia. You think it important that he has surgery fairly quickly, but you are aware the waiting lists at your local hospital are long. You question the patient about the possibility that the hernia was caused by an accident, explaining that if it were he might be able to have treatment funded by a local accident compensation scheme. He thinks that unlikely, but with a bit of prodding recalls that he did help a friend remove the motor from his boat 'a while ago', though he thinks well before he began noticing the symptoms which have brought him to you. You fill in the appropriate forms, identifying the occasion on which he helped with the boat motor as the probable cause of the injury.

At least some of the features of the earlier cases seem present here too: the general practitioner is faced with a decision whether to deceive a third party—the accident compensation scheme—in order to promote the patient's interests. (We can focus the case more directly

on 'health' interests by stipulating that the patient will not be able to afford private treatment without coverage. Without that stipulation the interests at stake are likely to be much broader, but to the patient perhaps no less important). Again, there is research which suggests that many health professionals are prepared to deceive 'third party payers' in order to secure treatment for their patients.[6-8]

But there are significant contrasts with the abusive partner case. There it seemed plausible that the patient had a right which could be secured only by lying. It may be that lying is the only way to secure funded treatment for the hernia patient too, but—as the need for deceit suggests—it seems much less plausible that he has a right to the benefit. Indeed, it seems more likely that he falls into a group which has quite carefully and openly been denied coverage. If we suppose that lying is in general wrong—justified only in exceptional cases—the absence of a legitimate interest which will be secured by the lie and offset the prima facie wrong of the lie should make us very wary about endorsing the lie. We may regret the limits of eligibility set by treatment payers. Unless they are plainly unjust, however, lying to subvert them seems unjustified. Doctors have an obligation to act for the good of their patients, and the cases we have discussed suggest that they may occasionally lie in order to do so, but it does not follow that lying is justified to obtain any health advantage for the patient.

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Common cold

Eccles R, Weber O, editors

Antibiotic use for the common cold

by Tim Kenealy and Bruce Arroll, p. 237–247

Reviewed by **Christine van Dalen** MBChB, FRNZCGP

This book is a very comprehensive account of all you every wanted to know (and probably a lot more) about the common cold. It is difficult to say who in particular the book is aimed at, but it is certainly of interest to doctors and nurses who come across this most common of human ailments in their day-to-day practice.

The book begins with a short history of the common cold that takes the reader on a fascinating journey through the ages from the Stone Age to the current day. Following this delightful chapter, there are several chapters on the symptomatology of the common cold that are particularly relevant to general practice medicine. The basic pathology of the common cold is covered in several chapters including epidemiology, virology and host defences. The chapters on virology are a little dry; however there are gems of information included in these chapters which make them worth working through. There are several chapters covering treatment options, including a chapter by Timothy Kenealy and Bruce Arroll on the use of antibiotics for the common cold. They have produced a succinct synopsis of this topic and addressed the difficulty of saying 'No!' to patients' expectations of antibiotic treatment. Three concluding chapters on over-the-counter remedies, vitamins and alternative remedies provide very interesting additional information that are likely to be helpful in providing advice to patients.

This book is very well written and surprisingly easy to read, including the chapter that has been translated from German. Each chapter is prefaced by a short abstract, and stands alone from the other chapters in the book, making it an easy book to put down and return to later. All the chapters are well-referenced should you see a need to read further, but I would think this unnecessary given how comprehensive this book is.

Although this book is not on my essential reading list, if you felt a need to know more about the common cold, this would be the book to read.

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