

Doctors who lie

SIR

Jennifer Jackson's disquisition on telling the truth (1) may be of interest to those unfamiliar with Sissela Bok's more sophisticated *Lying: Moral Choice in Public and Private Life* (2). Jackson concludes that doctors' "deliberate deception need not in general pose a significant threat to trust". In doing so she makes much of the role that polite conventions ("Very well, thank you"), fibs ("That suits you to a tee"), and subterfuges ("We have nothing planned for your birthday") play in private life, and which for her are "stratagems which we play on our friends with whom we care most to preserve trust" (3). (She might have considered jokes, stories, and exaggerations, words that we also distinguish from *lies*.)

Useful as this line of thinking might conceivably be for a private ethic for spouses, parents, lovers or friends it simply ignores the context in which we practise medicine. When doctors meet with patients they are emphatically not engaging in a private relationship, as traditional 'medical ethics' has long recognised. Surely, Jackson is not suggesting that doctors ought to see themselves as 'parents' providing for their patient 'children'?

Medicine is a public profession and doctors are indeed its knowledgeable experts: on pathogenesis and prognosis; on the interventions that might be employed; on *their* outcomes, risks and side-effects; etc. But being a patient, particularly in problematic cases, involves making decisions about what will happen to one, about choosing a treatment plan or how one wishes to spend one's last days, and making decisions depends upon access to good information: to as much of the truth as possible. Doctors are surely *not* experts on how I as a particular patient would decide (as many a doctor who has been a patient knows): whether I regard this side-effect as better than that, or prefer this altered lifestyle over that one. Nor are they experts in knowing how much information I need to come to a decision. And, as in the end it is I who have to live with the consequences of the medical choice that gets made, it is I who ought to choose among reasonable medical alternatives.

Certainly there are times when doctors ought to be economical with the truth (in Burke's sense, not Armstrong's!), and even circumstances that warrant proceeding without the patient's consent (in acute emergencies,

for short periods while competence is being determined, etc), but these rarely if ever warrant intentionally deceiving patients or their surrogates.

Perhaps a doctor who believes himself justified in lying, deceiving, or slanting the truth ought to be required to make a written record at the time, and subsequently be obliged to show it to the patient or his next of kin (4). I suspect that if this was done there would be a lot less "benevolent deception".

References and notes

- (1) Jackson J. Telling the truth. *Journal of medical ethics* 1991; 17: 5-9.
- (2) Bok S. *Lying: moral choice in public and private life*. New York: Pantheon Books, 1978.
- (3) Quotations from Jackson appear within double quote marks.
- (4) I am grateful to the unknown Cambridge student from whom I have derived this analogy with the procedures governing lying to research subjects.

R W I KESSEL,
*Limecroft, Shute Hill, Marlborough,
Devon TQ7 3SF.*

Ethics of preventive medicine

SIR

The paper by Dr Skrabanek (1) and the response by Professor McPherson (2) deal with the important issue of ethical constraint of preventive medical intervention. Their disagreement centres around the conflation of two, in effect, quite separate fields of ethical concern which impinge on the processes of evaluating and introducing health interventions. The issue becomes much clearer if we distinguish these two fields as pertaining respectively to the conduct of medical experiments involving human subjects, and to the much broader issue of balancing the benefits and hazards of intervention in deciding whether to make available or promote particular interventions within the community.

McPherson's argument acknowledges only the former of these two. He asserts that ethical scrutiny of experiments designed to assess the particular interventions is applied equally whether those interventions be drug-based or preventive, and argues that Skrabanek is therefore mistaken in asserting that preventive medicine is exempted from

ethical constraint. McPherson does consider the broader ethical field relating to the introduction of interventions, but interprets them only in terms of patient preferences.

Firstly, in order for a drug to be introduced into clinical practice it must receive a licence. For such a licence to be issued, evidence obtained from trials approved by local ethical committees must be presented, and the responsible authorities must satisfy themselves that introduction is justified on grounds of efficacy and safety. Until an objective means of quantifying benefit and hazard can be agreed the deliberations of these authorities must include value judgements including ethical ones. There is no similar process for licensing prevention interventions with the exception of vaccines. Furthermore when new drugs do become available, they can only be prescribed by medical practitioners, while as Skrabanek points out preventive interventions can be promoted by anyone.

Secondly, no drug for which the benefits and hazards have not been extensively characterised in trials will be granted a licence. Preventive interventions have and are introduced with only *a priori* justification, or on the basis of risk factor/disease associations, derived from epidemiological studies which may always be confounded. Skrabanek is right to assert that such interventions should be seen as experiments, and that there is a requirement for especially careful ethical scrutiny, given the large numbers of people whose lives may be affected by them.

While some of Dr Skrabanek's rhetoric about medical policing and Social Darwinism may be irrelevant to the issue, we should take care not, therefore, to discard his caution. His call for a broadly based and independent forum in which these often complex issues could be explored is timely given the recent publication of *The Health of the Nation* (3).

References

- (1) Skrabanek P. Why is preventive medicine exempted from ethical constraints? *Journal of medical ethics* 1990; 16: 187-190.
- (2) McPherson K. Ethics of preventive medicine. *Journal of medical ethics* 1991; 17: 162-163.
- (3) Department of Health. *The health of the nation*. London: HMSO, 1991.

DR ADRIAN RENTON,
*St Mary's Hospital Medical School,
Academic Department of Public Health,
Norfolk Place, London W2 1PG.*



Ethics of preventive medicine.

A Renton

J Med Ethics 1992 18: 49

doi: 10.1136/jme.18.1.49-a

Updated information and services can be found at:

<http://jme.bmj.com/content/18/1/49.2.citation>

These include:

Email alerting service

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:

<http://group.bmj.com/group/rights-licensing/permissions>

To order reprints go to:

<http://journals.bmj.com/cgi/reprintform>

To subscribe to BMJ go to:

<http://group.bmj.com/subscribe/>