

# The use of deception in nursing

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## Abstract

*Arguments about the morality of the use of deception in patient care have been conducted largely in an empirical vacuum, with few data about the situations in which deception occurs. Do staff frequently deceive their patients and, if so, under what conditions? Can the consequences of deception always be foreseen? What justifications do staff use to explain their behaviour? The small-scale study reported here on the uses of deception by nurses when attempting to reassure patients provides information on these questions. The results suggest that deception can have deleterious effects on trust and increase the emotional distance between patients and staff.*

Recent articles in this journal (1-3) have discussed some of the issues relating to deception in clinical encounters. Jackson (1,3) has argued that while lying is almost always morally indefensible, deception can be justified when it does not endanger the trust between a health professional and patient. Bakhurst (2), on the other hand, contends that lying and deception are often morally equivalent, because they infringe a patient's right to autonomy.

Hoffmaster (4) has argued that normative ethics provide a poor model for understanding the everyday ethical decisions made by clinicians since they do not provide a contextual understanding of action. In practice, doctors and nurses often override the rule of veracity in the interests of individual patients in particular situations. Frohock (5) concludes, on the basis of an analysis of treatment decisions in neonatal intensive care units, that the language of harm (the principle of non-maleficence) fits the reality of clinical practice more closely than the language of individual rights.

It seems likely that non-disclosure is widespread in patient care. Doctors and nurses frequently see it as part of their professional responsibility to 'titrate' the amount of information they give to patients. This can be justified on empirical grounds since some patients are distressed if they receive more information than they desire (6), but the use of

deception is another issue altogether. Deception is much harder to justify and certainly rarely acknowledged in public. Instead, many professionals prefer to use euphemisms such as 'information management' to describe times when they give inaccurate information or withhold accurate information in order to mislead.

It is sometimes argued that such situations should not be described as cases of deception, since the whole truth about a patient's situation can never be known or fully communicated; therefore one can never know whether or not the information which one gives is accurate or not. However, Bok (7) has pointed out that although we can never know the whole truth we still have the option of trying to convey the truth as we understand it. She argues that anything less is a form of deception, stating that: 'The moral question of whether you are lying or not is not settled by establishing the truth or falsity of what you say. In order to settle this question we must know whether you intend your statement to mislead' (8). Independent support for this viewpoint comes from studies in the philosophy of language which suggest that communication is best described as an inferential process in which one person uses language and non-verbal signs to try to induce another person to infer the intended meaning (9). Thus the key to deception depends less upon the precise coded form of words or other signs employed than upon the intentions of the communicator.

Empirical studies have indicated that deception is used to promote what is perceived as better care for the patient, sometimes through reassurance (for example, maintenance of hope for the future) and sometimes because of organisational needs (for example, time considerations or concern that a patient would become difficult to manage). In a small-scale survey by Schrock (10) of the deceptions used by student nurses, 60 per cent of the deceptive situations were attributed to doctors' orders or ward policy, 20 per cent were carried out in order to promote better patient management (since the nurses feared that if patients knew the truth they would be unwilling to comply with treatment) and the remainder of deceptions were carried out in order to withhold information about patients'

## Key words

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illnesses or drug treatments or because truthful explanations would have taken too long.

In a study of midwifery practice, Kirkham (11) observed frequent use of evasive answers to mothers' questions, amounting in many cases to deception. Mothers were allowed very little choice or autonomy during labour, and deceptive strategies were used to maintain medical and midwifery control over the situation. Bond (12) reported similar uses of deception in a cancer ward where the 'social order of the ward' was considered to require non-disclosure of diagnosis.

McIntosh (13), identified widespread use of deception by all members of the health care team working on a cancer ward. The team was consistent in its belief that disclosure of diagnosis would destroy patients' hopes of recovery and make their management difficult. McIntosh found that in many instances the patients themselves knew their true diagnosis, but supported the non-disclosure policy of ward staff. Glaser and Strauss (14) noted that nurses caring for patients with cancer were frequently hampered in their communication with patients by uncertainty over what patients already knew about diagnosis or treatment and by what they were allowed to disclose. Melia (15) in the UK found that student nurses faced similar problems, describing this as 'nursing in the dark'.

Although these studies indicate that deception is sometimes used in an attempt to manage situations, there are few indications of its 'success' or its effects on the professional-patient relationship. However, detection rates in real life may be high (16) and the pressures on those using deception increase when the message is an important one and when there are considerable adverse consequences of detection (17). In these circumstances, which are typical of clinical settings, social skills are more likely to break down and the likelihood of discovery to increase (18). The emotional costs of collusion in a deception may be considerable (19) and the need for teamwork in maintaining deception increases the risk of discovery (19). For all these reasons, the use of deception in health care is a relatively high-risk strategy.

The aim of the present study is to provide further empirical data on the use of deception in clinical settings. In a study on the use of reassurance in nursing (20), nurses were asked to describe situations in which they sought to alleviate patients' anxiety or distress. Those situations in which staff reported the use of deception form the database for this report. An analysis of these situations helps to develop a better understanding of the processes involved when nurses actively attempt to mislead a patient.

## Methods

### SUBJECTS

Ninety-one student and 126 qualified nurses working in medical, surgical, community and

psychiatric specialties were asked to complete a critical incident sheet (21) and 55 qualified nurses working in the same specialties were given a semi-structured interview. Although no personal details of the staff given the critical incident sheets were collected for reasons of anonymity, there were 12 male and 39 female nurses in the interview sample, with an average 16 years of nursing experience.

### PROCEDURES

The critical incident sheets asked the staff to describe situations when they (a) nursed a patient who was anxious, worried or distressed, (b) tried to help the patient become calmer, more secure or assured, and (c) were able to find out or observe the effects on the patient of their intervention. The semi-structured interviews with the nurses and patients covered the same areas but in more depth. Of the 272 nursing staff approached, 251 (93 per cent) agreed to describe such incidents. The two authors independently assessed the questionnaires and transcripts of interviews for the presence of deception or lying. The first author identified 13 incidents in which nurses used deception in their attempts to alleviate patients' concerns, while the second identified 12 incidents. Full agreement was found for ten incidents, which form the data-base for results described below.

## Results

### DESCRIPTIONS OF INCIDENTS

The 251 nurses indicated that they used a variety of interventions when attempting to help a patients to be calmer, more rested or secure. As shown in Table 1, the most common was the use of prediction (in which staff provided information about what was to happen to the patients), followed by emotional support (touching, providing time to listen), giving the patient some control over events, direct action (making some change in their care procedures) and distraction. Although deception was not given a category in this analysis, most instances involving deception fell under the prediction and distraction categories.

**Table 1**  
**Percentages of types of intervention used by nurses when attempting to reassure patients**

Prediction	41.2
Emotional support	29.1
Patient control	17.9
Direct action	7.7
Distraction	4.0

While the study collected incidents concerning community-based nurses as well as those working in hospital settings, all the incidents involving deception arose from hospital settings. The ten incidents of deception (four per cent of the total sample) involved two types of patients: in six cases the patients were intellectually impaired while the remaining four cases involved patients who were fully competent but who were undergoing diagnostic tests or treatment.

*(a) Patients with impaired intellectual abilities*

Six patients were suffering from confusional states or were mentally handicapped. In four of these incidents the nurses used lies to calm the patients, while in the remaining two they used truthful forms of words which were nevertheless designed to distract the patients from the objective reality of their situation. The aim appeared to be to help the patients 'calm down', at least in the short term, in order to avoid disruption on the ward. One example, with the deception in italics, illustrates the difficulties the nurses were facing at the time of the deception:

'She was pacing the corridor, trying to leave the ward. She was also repeating questions in a distressed way, starting to cry and threatening to hit people with her walking stick if they came too close ... I asked her if she would like to come and sit down and talk about the problem. She then repeated her questions about how she could get home. *I explained to her that she was in hospital and could not go home today as there was no transport on a Sunday. I also told her that her daughter and son-in-law would be coming to see her later in the day.*

In a second example, the patient had previously reacted poorly to changes in routine, so that the staff anticipated a strongly negative reaction to a planned move to another residence. Here, staff had come up with a 'devious package', in which the patient was deliberately misinformed about the likelihood that he would be required to move:

'The patient in question was living in an old mental handicap hospital. A new community bungalow was due to open in a few months and this patient fulfilled the admission criteria. It was planned that the patient would move when the bungalow opened, but the nurses were reluctant to tell him too far in advance because he had a history of becoming very anxious when under stress, leading to anti-social behaviour and a refusal to eat, with rapid weight loss. The patient became suspicious about the possibility of a move [and] *the staff decided to lie to the patient, saying that he would not be going to the new bungalow.*

In these and the other examples in this category, nurses were either reacting to or anticipating

distress, and taking steps to minimise or avoid it. As discussed later, such distress was seen as harmful to the patient but, perhaps more importantly, disruptive to the running of the ward.

*(b) Autonomous adult patients*

The remaining four situations involved adults who were competent, but whom nurses believed would suffer if they knew the truth. In such instances, the main objective was usually to reduce individual distress, rather than to minimise disruption. There were three examples of withholding information from patients suffering from cancer, in which the nurses used distraction techniques and gave evasive answers to patients' questions about diagnosis or prognosis. Either the patient's consultant had taken the decision to withhold the information about diagnosis, or the family had requested this, or a nurse had decided not to volunteer an opinion about the patient's prognosis. For example:

'I had a gentleman who had been admitted with cancer of the knee who had come in for various operations to have little bits removed. But all the time we could see that he was deteriorating. There wasn't much hope of a recovery. We'd built up a good relationship and a very good friendship within that. He trusted me. *We kept getting the feeling that he wanted to know what was happening, but the consultant in particular was very evasive.* Then a friend of his who was a GP came in to see him and told him the truth.'

'The patient was suffering from myeloma, a form of leukaemia. As part of her treatment she needed blood transfusions which she had in the past found particularly painful. The doctors were putting off telling her about her diagnosis due to her anxiety problems and a history of cancer phobia. Cancer was something she could not cope with. *I did say that the doctors were still trying to find the cause of the anaemia but had to treat it by blood transfusions if she was to start feeling more well.*

In addition, there were two instances where information was not given to patients even though nursing staff possessed relevant knowledge:

'A female patient aged 49 years had come into hospital for an operation on her hand. The anaesthetist had explained the operation to her and told her that he had prescribed paracetamol, in case she had any post-operative pain. The patient experienced a great deal of pain when she awoke from the anaesthetic and this led her to believe that the operation must have gone badly. She told me how painful her hand was and I got a doctor to prescribe a stronger pain-killer. I said: *"I didn't like to tell you this before, but I had this operation done two years ago and the pain I had for about 48 hours afterwards was awful"*.'

'The man's pet had gone to a friend's but they'd put it down because they couldn't handle it. And the patient was with us awaiting placement in a place where they don't take pets. And he was asking about the dog, but we really couldn't tell him that the dog was no longer with us. *We were saying "You will get to see him sometime". Really it didn't seem appropriate to tell him.* He had a couple of episodes where he got quite agitated and a little bit aggressive, so actually telling him the truth might have made him aggressive. I don't think anyone was against not telling him, we all thought it was for the best. And at handover we would discuss it.'

#### CONSEQUENCES OF DECEPTION

Staff were also asked to outline the effects of their attempt to relieve anxiety or distress. For the intellectually impaired patients, the short-term consequences were generally positive, as for the woman pacing the corridors:

'She seemed very happy about this and, after a cup of tea, settled down again, saying thank you to me for helping.'

The mentally handicapped individual grew gradually accustomed to the idea of moving to the bungalow after a few 'visits'. In the case of the gentleman whose dog had been put down, he was moved to a nursing home without being told, so the consequences were unknown.

However, the nurses recognised that there could be longer-term difficulties when the patients were competent and staff had to face the consequences of their behaviour. Sometimes this was because communication patterns between staff are complex in the hospital environment and subject to misunderstandings. In such instances the consequences were not foreseen. In the case of the cancer patient who had been told of his diagnosis by his GP, for example:

'Unfortunately before I went off duty for a weekend I had indicated to one of my members of staff that the patient now knew his condition, knew his diagnosis and that people could be open with him. Because everyone else who had grown particularly attached to him was also finding it difficult that there was this sort of barrier ... and it was almost like everybody was role-acting ... playing a part. So I let this member of staff know that this had occurred. Unfortunately this member of staff didn't pass it on to the others. So all weekend he wanted to talk about it but they carried on being evasive. Consequently that added to the patient's distress and added to mine. I think that shattered a lot of trust.'

And in the case of the woman who had an operation on her hand:

'The patient asked me why I did not warn her of [the post-operative pain] and I replied "I didn't want to frighten you, because you thought it wasn't going to hurt very much". The patient reported feeling shocked at this, saying that she would have preferred to have known what to expect.'

#### EXPLANATIONS OF THE NURSES' ACTIONS

In some cases the nurses explained the reasons for their actions, but in other cases these must be inferred from the context. Sometimes nurses reported that they were using deception at the request of the patients' families and/or at the request of consultant medical staff. The difficulties of maintaining deception when patients were aware of their worsening physical condition were noted.

In most incidents the nurses explained their actions on grounds of non-maleficence. They used deception to keep the patients from becoming more anxious about their condition, their treatment, or their family. The nurses considered that they were acting positively to benefit their patients by giving them false information which they believed would relieve their anxiety. For the man whose dog had been put down and for the mentally handicapped resident, deception was used to facilitate management because the nurses feared these patients would react aggressively to the truth.

It is not possible to judge from these incidents the full extent to which the nurses engaged in ethical debate before using deception. In two cases (the patient with learning difficulties and the patient whose dog had died) the nurses reported that they discussed the various courses of action open to them before adopting deception. The nurse's reasoning behind her decision to withhold information about post-operative pain appeared unclear. When the patient reported pain, the nurse immediately contacted a doctor to have the patient written up for a stronger analgesic – yet she took no action before the operation either to alert the patient as to what to expect or to get the doctor to alter his prescription in anticipation. When the nurse admitted her deception after the event to the patient, this undermined the patient's trust in the way her care had been managed.

#### Conclusions

Although the database is limited, a number of tentative conclusions can be reached. First, it should be noted that on only ten occasions was deception used in the sample of 251 incidents, even though the questionnaires were completed anonymously so that there was no 'public' disclosure of deception. While it would be unsound to draw any firm conclusions from this small number of reported incidents as to the actual frequency with which deceptive strategies are used by nurses (the sample is not representative of the nursing profession as a whole and the study itself treated deception as only one among a much

wider array of strategies used to alleviate patients' worries), it appears the use of deception is rare.

Second, the data provide some indication of the reasons for the deceptions. Staff usually perceived themselves as acting under the principles of beneficence or non-maleficence. However, another possibility is that deception was used for organisational reasons, in order to ensure the smooth running of the ward. For example, the nurses who did not disclose the dog's death or the move to the bungalow were concerned about aggressive reactions as well as doing no harm. It seems harder to justify the deception in such instances, although it can be argued that the welfare of other patients was relevant. It is also important that many of the incidents involved patients without full intellectual autonomy, who were less likely than others to uncover the deception.

Third, the results bear on Jackson's (3) contention that deception can be justified in certain circumstances when it does not have an adverse effect on the relationship – especially the trust – between patient and professional. These cases illustrate that it is not always possible to foresee the consequences of deception. Even when the nurses were apparently working under the principles of beneficence and non-maleficence, the longer-term consequences were sometimes negative. It was particularly difficult to co-ordinate deception when patients were intellectually unimpaired, and eventual discovery sometimes had an adverse effect on the nurse-patient relationship. Furthermore, both deception and discovery resulted in some distress for the nurses themselves and could lead to what was termed 'playing a part'. Thus it seems unlikely that the consequences of deception can be foreseen with great accuracy. Even though the intention might be innocent, whether a deception will be discovered cannot always be predicted.

Finally, it is useful to note that nurses varied in their willingness to use deception in their dealings with patients. Some nurses in the larger sample reported that they would never seek to mislead patients and would always disclose the truth about a situation if they knew it and believed that the patient was genuinely seeking an honest answer. Other nurses disputed this, believing for example that relatives have the right to direct staff not to disclose information. This is a field where further descriptive study would be of value in order to increase knowledge of the range of situations in which deception is used by nurses and by other health care professionals. The development of a theoretical model which could account for such differences in behaviour would be of great value in understanding the role of deception in practice. Self-reports in the form of critical incidents and interviews with staff and patients are two methods of eliciting this information.

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