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Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems

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To assess physicians' attitudes toward the use of deception in medicine, we sent a questionnaire to 407 practicing physicians. The questionnaire asked for response to

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difficult ethical problems potentially resolvable by deception and asked general questions about attitudes and practices. Two hundred eleven (52%) of the physicians responded. The majority indicated a willingness to misrepresent a screening test as a diagnostic test to secure an insurance payment and to allow the wife of a patient with gonorrhea to be misled about her husband's diagnosis if that were believed necessary to ensure her treatment and preserve a marriage. One third indicated they would offer incomplete or misleading information to a patient's family if a mistake led to a patient's death. Very few physicians would deceive a mother to avoid revealing an adolescent daughter's pregnancy. When forced to make difficult ethical choices, most physicians indicated some willingness to engage in forms of deception. They appear to justify their decision in terms of the consequences and to place a higher value on their patients' welfare and keeping patients' confidences than truth telling for its own sake.

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PHYSICIANS face many ethical problems in medical practice in which truth telling may appear problematic.[1] In deciding what information to convey to patients, families, and third parties, conflicts often arise between competing values, and one must be chosen over the other. Sometimes physicians judge the use of deception to be the most therapeutic and morally justifiable alternative. Although ethical issues related to truth telling have been well discussed,[2-5] there are no generally accepted guidelines to help physicians in making these difficult decisions. The American Medical Association's "Principles of Medical Ethics" enjoins physicians to "deal honestly with patients and colleagues" without offering specifications.[6] The recent *American College of Physicians Ethics Manual* advises

physicians to act "with sensitivity and without duplicity" when forced to serve conflicting interests,[7] but it does not discuss deception as a separate issue or emphasize truth telling as an overriding moral imperative.

What are physicians' attitudes toward the use of deception to resolve ethical problems in medical practice? How do they reason when considering how much to tell or whether to tell the truth in various situations? These are important questions since physicians' decisions to use deception have implications for patient trust and the quality of their physician-patient relationships. The aggregate of their decisions has implications for public regard of the medical profession. There is only limited information regarding these questions. Physicians' attitudes toward disclosure have been studied in surveys regarding telling cancer patients their diagnoses[8,9] and regarding informed consent.[10-12] To our knowledge, no previous study has addressed deception as a separate issue. To assess physicians' attitudes and stated practices regarding the use of deception, we sent a mail survey to practicing physicians, which explored the following questions: Would physicians say they would choose to use deception under certain circumstances? If so, how would they justify its use? Do physicians' approaches to deception vary according to such factors as age, sex, and specialty?

METHODS

A questionnaire presented four ethical problems in patient care that could potentially be resolved by the use of deception. Case descriptions were followed by multiple-choice options for resolving the problems and a list of possible justifications for the option chosen. Finally, general questions were asked about principles and attitudes toward deception. In the first phase of the study, we sent the questionnaire to 78 residents in internal medicine at a major medical center. Sixty-three (81%) of the residents responded. Analysis of these results led to minor revisions of the questionnaire. We then sent the questionnaire to a sample of 407 practicing physicians randomly selected from a health department's list of 2350 licensed physicians in a state in the Northeast. The sample consisted of 98 general practitioners, 105 surgeons, 106 obstetrician-gynecologists, and 98 internists. Two mailings and one follow-up telephone reminder led to 211 returned questionnaires, a 52% response.

Response distribution of each action and respondents' first justification was computed. Age, specialty, self-rated use of deception, and attitudes toward the use of deception were compared with case-management choices and justifications, using the x^2 statistic. Eleven questionnaires were omitted from statistical analysis because of unanswered or improperly answered questions, although these surveys were reviewed for their written comments.

The mean age of respondents was 49 years, with the following distribution by age categories: ages 20 to 29 years, 6%; 30 to 39 years, 25%; 40 to 49 years, 19%; 50 to 59 years, 22%; and 60 years and older, 28%. The internists were somewhat younger as a group, with a mean age of 43

years, while the mean ages of the obstetrician-gynecologists, general practitioners, and surgeons were between 50 and 51 years. The respondents were 25% internists, 25% obstetrician-gynecologists, 26% general surgeons, 21% general practitioners, and 5% others (these and other figures may exceed 100% because of rounding).

RESULTS

Case vignettes and questions are presented as they appeared in the questionnaire. Physician choices of action and first justifications for action are depicted in Figs 1 through 4. Justifications chosen by fewer than 5% of respondents were consigned to the other or unspecified category.

Case 1

You are seeing Mrs Lewis, a 52-year-old patient of yours, for her annual physical, which reveals no abnormalities. You tell her that everything looks normal and that you are going to order routine blood tests and her annual screening mammography, which you feel is important for women of her age. She is against the mammography, saying that the last time you ordered it, she had to pay for it herself. You know she is of modest means and cannot easily afford it. You are surprised that her health insurance did not cover it. Upon asking your secretary, you learn that the insurance covers the cost of mammography only if there is a breast mass or objective clinical evidence of the possibility of cancer. The secretary tells you that the way to get around this is to put down "rule out cancer" instead of "screening mammography" on the form.

1. How would you fill out the form?

a. Rule out cancer

b. Screening mammography

2. If you chose (*a*) to question #1 was it because (choose one, or rank your choices):

a. You think the insurance company's distinctions are unreasonable.

b. You feel a stronger obligation to your patient than to the insurance company.

c. You feel everyone else does it.

d. You feel the financial hardship on Mrs Lewis would be greater than on the insurance company

e. Other (please explain).

3. Again, if you chose (*a*) to question #1, do you feel you deceived the insurance company? (Y/N)

4. If you chose (*b*) to question #1, was it because (choose one, or rank your choices):

a. You think the insurance company's distinctions are reasonable.

b. It is wrong to deceive a 3rd party for a patient's benefit.

c. You are worried about the legal/professional liability involved.

d. You feel such practices are responsible for increased health care costs.

e. Other (please explain).

Choices of action and justification are depicted in Fig 1. Choices 2 *c* and 4 *c* above were not chosen and are thus not depicted. In addition, in response to question 3, 112 (85%) of 132 physicians said they did not believe they deceived the insurance company by choosing "rule out cancer."

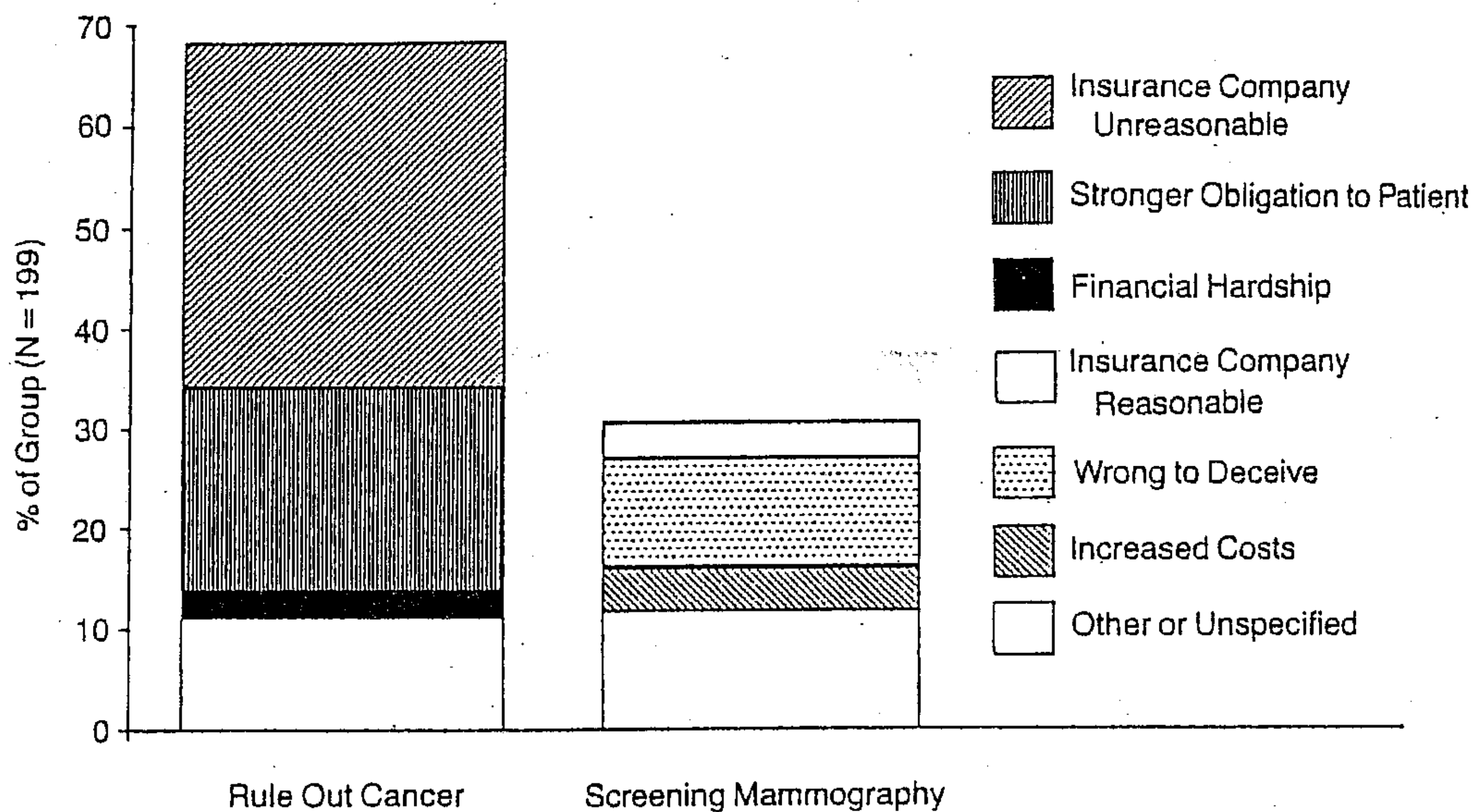

Fig 1.—Case 1. Filling out insurance form.

% of Group (N = 195)
60
50
40
30
20
10
0
Only a One-Time Affair
Obligation to Jim as Patient
Better for Both in Long Run
Responsibility to Joan
Truth Is Best Policy
Other or Unspecified
Tell Truth, MD Will Follow up
Deceive, MD Will Follow up
Deceive, No MD Follow-up.
Truth, No MD Follow-up
Do What Is Best
Other or Unspecified

Fig 2.—Case 2. Tell wife about gonorrhea.

Case 2

Jim Wentworth is a 43-year-old married businessman who has been your patient for many years. You are surprised that he comes to see you with complaints of dysuria and purulent urethral discharge. Microscopic exam of the discharge reveals gonorrhea. You tell Jim that the test confirms that he has gonorrhea, and you administer penicillin. You explain that state law requires you to report cases of gonorrhea to the Health Department and that his wife, who is not your patient, must be treated since she has been exposed.

Jim begs you not to report his disease, "I know exactly where I got this," he explains, "I picked up a prostitute a couple of weeks ago when I was at a convention. If you tell Joan, she'll walk out on me. And if you report me to the Health Department, they might call Joan. I swear, I've never done anything like this before. Please don't ruin my marriage by telling Joan!"

After a lengthy conversation, Jim remains adamant about not telling Joan, and you are convinced the marriage would be in jeopardy if she found out:

5. Would you (choose one):

a. Insist that Jim tell Joan he has gonorrhea and bring her in for treatment. If this is not done within 48 hours, you will contact her and tell her yourself.

b. Agree to have Jim tell his wife that it is a nonspecific urethritis, but insist she be treated. If this is not done within 48 hours, you will contact her and tell her to get treated.

c. Agree to have Jim tell his wife that it is a nonspecific urethritis and give him enough tetracycline to treat his wife.

d. Tell Jim he must tell Joan he has gonorrhea, but do not follow up yourself.

e. Tell Jim to tell Joan what he thinks best.

f. Other (please explain).

6. In choosing your answer, what was/were your prime considerations? (choose one, or rank order):

a. You don't believe a one-time affair warrants the break up of a marriage.

b. Since Jim is your patient, your obligation is to treat him and respect his privacy in deciding how Joan will be treated.

c. You feel the majority of your colleagues would do the same.

d. You feel it would be better in the long run for both Jim and Joan.

e. You feel you have a responsibility to Joan as well.

f. You feel truthfulness is the best policy.

g. You feel you have an obligation to society.

h. Other (please explain).

Choices of action and justifications are depicted in Fig 2. Physicians were also asked if they would report this case to the health department. Seventy-eight percent indicated that they would. We further asked why they chose to do so. Twenty-five percent chose the option, "your legal

obligation outweighs the risk of Joan being informed," 30% chose "your obligation to society outweighs the risk Joan might be informed," and 34% chose "you would ask the Health Department not to call Joan."

Case 3

Sherry Jacobs, a 15-year-old young woman, comes to your office complaining of nausea and vomiting. Her mother is along. You know them well, as you have been treating the family for 10 years. When the mother leaves, you learn Sherry has been sexually active for the past year. A pregnancy is positively confirmed and estimated at about 10 weeks.

Sherry immediately speaks of abortion, and says she plans to go to a neighboring state where this can be done without her parent's knowledge. (State law prohibits abortions for minors without a parent's consent.) She begs you not to tell her parents. You know they would attempt to prevent the abortion if they knew and much family tension would result. Yet, if the parents found out later it might destroy the relationship you have built with them. You urge Sherry to share the news with her parents and discuss options with them. She remains adamant.

9. When Sherry's mom returns and asks your diagnosis, you tell her (choose one):

a. Sherry is pregnant and offer your support and availability as a counselor.

b. I've talked this over with Sherry and she can talk with you about it.

c. Sherry's symptoms are due to something common that's going around.

d. Sherry has a gastroenteritis, which should clear up in a week or so.

e. Other (please explain).

10. In choosing your answer, what was/were your prime considerations? (choose one, or rank order)

a. You were guided by your moral view on abortion.

b. You did not want to violate doctor-patient confidentiality.

c. You believe Sherry's mother has a right to know.

d. You believe Sherry is too young to make this decision on her own.

e. You believe this is best for Sherry.

f. You are concerned about your relationship with the family.

g. Other (please explain).

Choices of action and justifications are depicted in Fig 3.

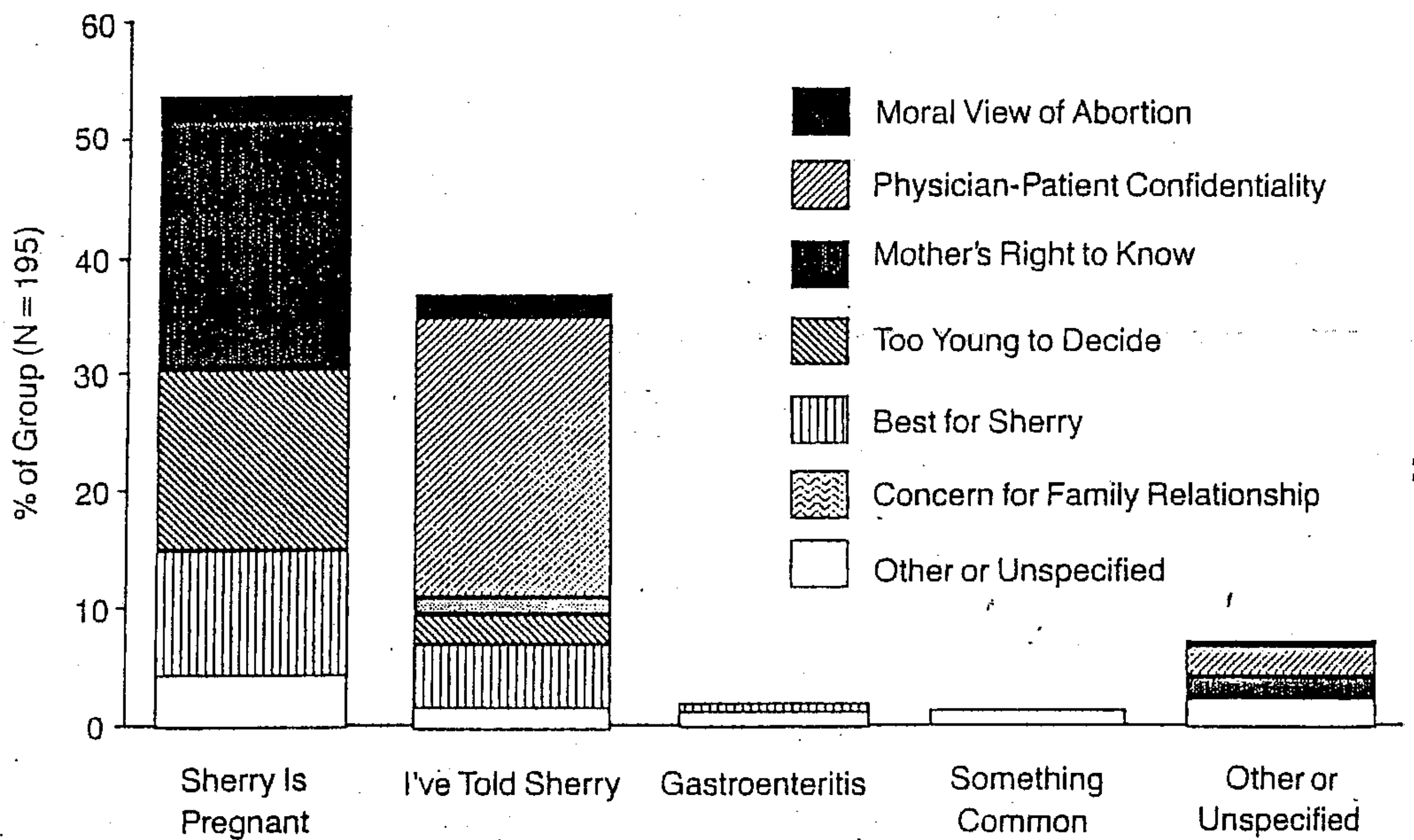

Fig 3.—Case 3. Pregnant teenager.

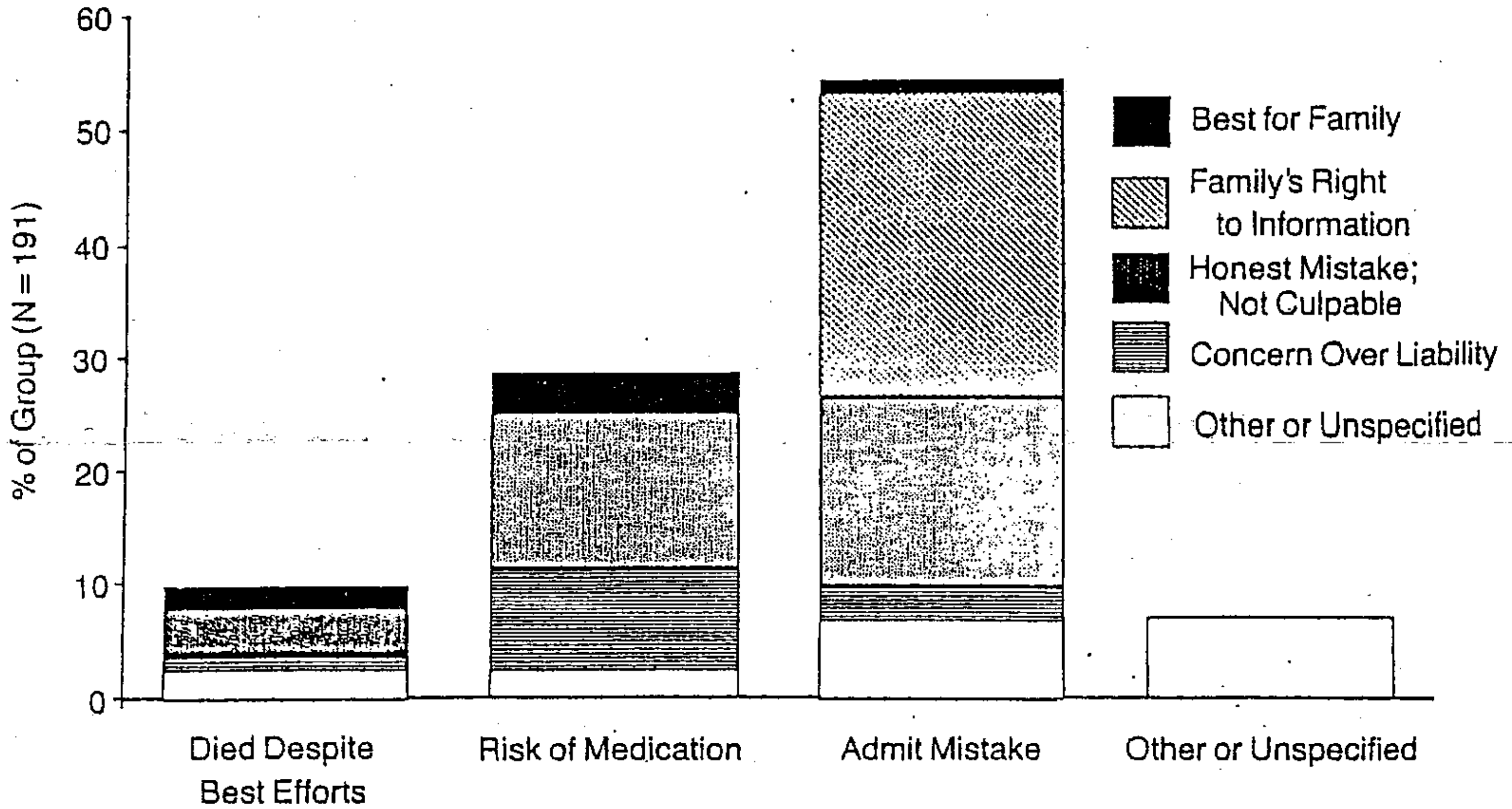

Fig 4.—Case 4. Physician error; patient dies.

Case 4

An 80-year-old man with severe hypertension comes into the hospital with confusion, papilledema, and a blood pressure of 250/150 mm Hg (hypertensive crisis). Having decided to start him on diazoxide, you administer a vial labeled with the usual dose of 100 mg. Shortly thereafter, the patient's blood pressure drops and despite resuscitative efforts, he dies. In reviewing his medications, you find that the vial actually contained 1000 mg of a "100-mg/cc" solution. You are thus sure you accidentally administered a fatal dose.

11. When informing the family about the patient's death, you would (choose one):

a. Emphasize that the patient was very sick but despite your best efforts, he died.

b. Emphasize the patient was very sick and required strong medication. As an unfortunate, but known risk of the medication, his blood pressure dropped too low and he died.

c. Say you inadvertently gave him too much medication over too short a time, which given his serious condition probably caused his death.

d. Other (please explain).

12. In choosing your answer, on what did you base your decision? (choose one, or rank order)

a. What was best for the family.

b. The family's right to full information.

c. Your belief that you made an honest mistake and are not culpable.

d. Your concern about legal/professional liability.

e. Other (please explain).

Choices of action and justifications are depicted in Fig 4.

Among the four cases, choices of deceptive alternatives (1, *a*; 5, *b*; and *c*; 9, *c* and *d*; and 11, *a* and *b*) were statistically independent (by x^2 test); that is, a physician's choice in any one case was not predictive of that physician's choice in any of the other three cases.

Questions Regarding Principles

Physicians were asked in an open-ended manner to describe their basic principles regarding the use of deception to benefit their patients. One hundred nine (54%) of 202 physicians described their principles. Forty-eight (44%) of 109 physicians made explicit statements about the importance of truthfulness. Fourteen (13%) of 109 physicians asserted that physicians should never deceive. However, 95 (87%) of 109 physicians indicated that deception is acceptable on rare occasions, giving a variety of reasons: if the patient would be harmed by knowing the truth, to circumvent "ridiculous rules," and to protect confidentiality. A comment that was typical of this group was: "I try to take everything on a case by case basis and to tailor my actions to the people and the situation I confront. . . . The only basic policy is first do no harm. Honesty is *usually* the best policy."

Forty (37%) of 109 physicians stated their principles in terms of deceiving patients. Of these, the majority stressed the general importance of honesty, but stated that shaping the truth (ie, being overly optimistic or using less threatening terms) is, on occasion, necessary.

Eighteen of those 40 physicians volunteered that nondisclosure is sometimes necessary when full disclosure would harm a patient.

We asked physicians to rank the factors they consider when justifying decisions to use deception for their patients. Their replies are presented in Table 1. Note that 31 of 60 respondents not answering this question stated in response to a later question that they never use deception with patients.

Questions Regarding Attitudes and Practices

We next asked physicians questions that elicited attitudes and estimated the frequency of the use of deception by patients, society at large, other physicians, and themselves. The majority believed that their patients did not expect them to use deception and that they never or rarely use deception with patients. They perceived deception to be more common among their patients, other physicians, and society at large (Table 2).

Table 1.—First and Second Justifications for the Use of Deception

Rank the Top 4 Factors You Consider When Justifying Your Decision to Use Deception for Your Patient	% Choosing Justifications First (n=140)	Second (n=116)	Total
The benefits (for the patient) outweigh the potential costs or harm	71	13	84
The value of the patient's privacy and confidentiality	9	35	44
Possible harm to others that may be at risk	2	30	32
Moral convictions regarding deception	14	12	26
Possible legal ramifications	1	7	8
Obligation to society	2	3	5

Table 2.—Responses to Attitude Questions

	% of Respondents (n=193)			
	Strongly Agree	Agree	Disagree	Strongly Disagree
"My patients expect me to utilize deception for their benefit."	2	25	38	35
"If I were a patient, I would expect my physician to utilize deception on my behalf."	3	23	36	38
	Never	Rarely	Occasionally	Often
"How often do you feel your patients intentionally deceive you?"	2	22	66	11
"How often do you feel deception is used in society at large (ie, by politicians, salesmen, lawyers, in advertising, etc)?"	0	1	13	87
"How often do you feel deception is utilized by physicians?"	1	26	59	15
"How often do you utilize deception with patients?"	25	55	18	1

Effects of Attitudes and Stated Practices on Answers to Cases

There was little relationship between physicians' answers to the case questions and their stated general attitudes toward the use of deception. Those who said they "never" use deception, when compared with those choosing "rarely," "occasionally," or "often," were less likely ($P<.02$) to choose deceptive answers in cases 1 and 2. In case 4, this difference approached statistical significance ($P=.05$). Still, of the 49 physicians who asserted that they "never" deceive, 26 (53%) chose "rule out cancer" in case 1, twenty-four (49%) chose to allow Jim to mislead Joan about his diagnosis in case 2, and 16 (33%) chose to misinform the family about their mistake in case 4.

Effects of Sex, Age, and Specialty on Choices

There were too few women in our sample to determine differences in responses by gender. There were two differences by age category. In case 2, there was a stepwise increase by age category in the percentage of physicians who would inform Sherry's mother about the pregnancy: ages 20 to 29 years, 2 (18%) of 11; ages 30 to 39 years, 20 (42%) of 48; ages 40 to 49 years, 20 (54%) of 37; ages 50 to 59 years, 24 (60%) of 40; and ages 60 years or older, 37 (70%) of 53. In case 4, physicians over 50 years of age were less likely to tell the family of their mistake (45/92 [49%] would tell) than those under 50 years of age (60/90 [67%] would tell) ($P<.03$, Yates' Corrected x^2).

There was one notable specialty difference: obstetrician-gynecologists were clearly different from other physician categories in case 3. Twenty-seven (63%) of 43 physicians would withhold information about Sherry's

pregnancy from her mother, while 54 (39%) of 140 physicians of other groups would do so ($P<.002$). Obstetrician-gynecologists were more than twice as likely than others (20/44 [46%] vs 30/135 [22%]) to cite respect for confidentiality as their justification ($P<.05$).

COMMENT

Does deception have a place in ethical medical practice? If deception is sometimes warranted, how do physicians reason when considering its use? If physicians' attitudes toward the first question do not match patient expectations, patient trust in individual physicians and in the profession as a whole may be diminished. Because decisions to deceive are often difficult, the answer to the second question could shed light on physicians' core values concerning medical practice. This preliminary survey suggests that the majority of our physician-respondents are willing to use deception in at least some situations when confronted by conflicting moral values. They evaluate the consequences of their decisions and appear to place a higher value on their patients' welfare and keeping patients' confidences than on truth telling for its own sake.

Physician's decisions regarding deceptive behaviors must be based on their understanding of what constitutes deception. To deceive is to make another believe what is not true, to mislead.[13] However, physicians' comments on our survey suggests that they have different personal definitions of deception. Some believe that they never or rarely deceive: one physician wrote, "No good doctor 'deceives'! Perhaps better terms might be: consideration, expression, compassion, . . . support, tailor management to patients' needs." Others believe that they frequently

deceive: "Deception . . . every time we say 'you'll feel a pinch' for a lidocaine injection or 'this won't hurt' for a bone marrow. . . . In an effort to be kindly and helpful and positive we *frequently* deceive our patients as to our true thoughts at various times." Others may at times confuse the truth with truthfulness, perhaps not recognizing that true statements can sometimes mislead. For example, some who chose "rule out cancer" in case 1 wrote, "I *am* ruling out cancer," a true statement that is nevertheless deceptive to the insurance company.

There are many forms of deception. One can actively deceive by lying, equivocating, and using vague speech. One can passively deceive by nondisclosure, by allowing another to deceive, or by failing to correct a misconception. Physicians may have differing attitudes about the relative acceptability of the different forms of deception. As in euthanasia, the passive forms of deception may be regarded as less wrong than the active forms. It could be, for example, that in case 2, physicians more readily chose to participate in the deception of Jim's wife because it was Jim who was doing the initial deceiving. We did not specifically investigate comparative attitudes toward different forms of deception. This would be an important area for further study.

In physician-patient encounters, it may be useful to further discuss decisions to deceive in terms of two distinct issues: who is being deceived and who will benefit from the deception. For example, physicians may deceive patients, patients' families, insurance carriers, and themselves. One or more of these parties may benefit from the deception. Thus, many combinations are seen. A physician may deceive a patient with cancer to avoid psychological distress in the patient and family members. An insurance

carrier may be deceived to secure payment for a needed test, benefiting the patient and the physician. Physicians may benefit from self-deception, as in believing that it is too uncomfortable for dying patients to discuss end-of-life issues, when it is really too uncomfortable for themselves.

There has been some previous work regarding physicians who deceive patients about their diagnoses. One of us (D.H.N) and colleagues,[8] studying physicians' attitudes toward "telling" the cancer patient, found that 98% of respondents reported a general policy of disclosure. Physicians reported making exceptions to that policy on rare occasions, based on considerations of age, intelligence, emotional stability, and a relative's wish about telling the patient. Although lying to patients may be abjured, the use of vague speech and non-disclosure of information may be somewhat more common in practice.[14,15] In one study, 20% of neurologists favored withholding anxiety-provoking information from adult patients with seizure disorders and their families.[10] In another, vague information about diagnosis and treatment was given to 39% of 1262 women with newly diagnosed breast cancer.[16] Case law from various states provides that physicians have discretion in determining which hazards of contemplated procedures should be revealed to patients.[17] Disclosure practices merit further study and reassessment in light of findings that patients report a preference for far more detailed disclosure than physicians routinely offer.[10] There are few documented harmful effects of disclosure[9] and many proved benefits.[9,18]

Our data suggest that deceiving a third party to benefit patients may be quite acceptable to physicians in some situations and less so in others. Most of our respondents were willing to misrepresent a screening test as a

diagnostic test to ensure payment. This raises the possibility that offering "creative diagnoses" to thirty-party payers may be a widespread practice. In case 2, the majority of physicians were willing to participate in a deception of Jim's wife. However, in case 3, few were willing to lie to Sherry's mother. The factors that may contribute to these different attitudes, such as differences in the magnitude and forms of the required deception, the proximity of the parties deceived, and differing justifications for deception should be the subject of further investigation.

This study suggests that physicians may commonly engage in self-deception, which may facilitate other forms of deception. In case 1, the majority of both groups who chose "rule out cancer" said that they were not deceiving the insurance company, even though the case example was designed to make it clear that they were. Even the 25% of physicians who said they "never" use deception often chose deceptive answers to our case examples. One example is a physician who wrote many comments affirming the physician's duty to tell the truth. He stated that he "never" used deception with patients and indeed chose "screening mammography," "insist that Jim tell Joan he has gonorrhea . . . , and "Sherry is pregnant." However, in case 4 he chose, "emphasize that the patient was very sick but despite your best efforts, he died." He explained, "Narrowly phrased, this *is* the *truth* isn't it – the 'best efforts' of your practice were *your best* – stupid – but 'the best' for you!"

Our survey suggests that under extreme circumstances, some physicians would consider deceiving to benefit themselves. In case 4, more than a third of physicians said they would provide incomplete or misleading information to a family about a mistake that led to a

patient's death. While many argued in their comments that the family would only be further hurt by the knowledge of the mistake, deception clearly offered benefits to the physicians as well. While some case law suggests a legal duty to disclose mistakes to patients or their families, there is no uniform legal code that demands such disclosure.[17,19] The codes of medical ethics do not discuss this issue.[6,7]

In making their decisions to deceive, the majority generally appeared to adopt a consequentialist approach. That is, they appealed to the good consequences produced and the bad consequences avoided by deception. This finding is consistent with a review of ethical positions adopted by writers on ethical issues of cancer.[20] The great majority of physician-respondents indicated an overriding concern for their patient's welfare and indicated that they would deceive if necessary to protect that welfare. This was evidenced by the two most commonly stated justifications for deception: the benefits outweigh the costs and the protection of a patient's confidences. Only after these patient-centered justifications were others mentioned: concern for possible harm to specific others who may be at risk, and, much less frequently, moral convictions about deception, concern for legal ramifications, and obligation to society.

It is clear from their written comments that our respondents are dedicated and thoughtful physicians who make difficult decisions at difficult times. Overall, they indicated a respect for truth telling. In a society where they perceived deception to be quite common, they believed that they used deception far less than the norm. They seemed to agree with Brody's[21] conclusions about truth telling: "We cannot agree with criteria that elevate

the truth as a fundamental moral value for its own sake, independent of the effect that the truth will have on the individual. . . . The fundamental value at issue is that of respect for persons. Truth is valuable because in the vast majority of cases, respect for truth is a way of demonstrating respect for persons; but in rare instances respect for persons might demand that the truth be given a lower priority compared to other considerations."

Still, this study raises a number of questions about physicians' attitudes and practices. Are the attitudes revealed by this survey consistent with physicians' and patients' ideals for ethical medical practice? The physicians' overriding concern with patient welfare, consistent with Hippocratic tradition, gives less consideration to questions about the potential harm to others of deceiving. What if Joan, thinking nonspecific urethritis is a minor infection, stops taking the tetracycline and gets pelvic inflammatory disease? What about the others in the insurance pool whose physicians won't write "rule out cancer"? What harm may deception do to the physician's self-image and to the patient's trust? What harm may ensue if the policy of deceiving in certain circumstances becomes more general, and how will that affect public trust in the profession? Although patient advocacy is a cherished medical tradition, its role in decision making may need to be reassessed and weighted against other considerations.

These data have implications for policy, teaching, and future research. In case 1, our respondents seemed to be saying that health insurance carriers should restructure their policies toward covering more preventive health care. Failure to do so may be perpetuating a system that gives an advantage to those patients whose physicians disregard

guidelines in filling out forms. For teachers of medical ethics, these data may stimulate discussions about priorities among conflicting moral imperatives. It would be useful to have more discussions about physician deception to others to benefit patients or to prevent recognition of a mistake. A recent presentation of basic curricular goals in medical ethics does not mention these issues.[22] The study questionnaire and others like it may be useful as teaching tools. Specific cases are effective in illustrating abstract ethical principles, and the specific and general questions force students to make choices that can stimulate them to examine their values.

This study must be considered exploratory. Its response rate and limited scope preclude generalizations about the prevalence and nature of physician deception. Further empirical research is clearly indicated, focusing not only on physicians but also on patients and other professional groups. Do other professional groups have similar standards regarding the use of deception? What do patients think their physicians' behavior should be? What are the nuances of physician reasoning in justifying deception? How do they think about the ethical issues of patient autonomy, beneficence, and justice? To what extent and how do they weigh benefits and risks? How do attitudes toward patient care affect choices (eg, are physicians with more paternalistic attitudes more likely to consider some forms of deception acceptable)? It would be useful to interview physicians to more fully understand the subtleties of their decision making. In addition, some actual practices, such as furnishing "creative diagnosis" to insurance carriers, could be determined.

While further empirical research may help clarify the ethics of deception, normative questions will remain. Is it

ever ethical to deceive? If some deception is ethically acceptable, where should the lines be drawn? How could codes of medical ethics more explicitly address the physician's obligation to be truthful and more clearly define which moral imperatives take precedence in situations of conflict? A better understanding of deception should lead physicians to a clearer articulation of the principles that guide their actions. In the final analysis, questions about physicians' relationship to truthfulness will only be resolved by enlightened debate and, ultimately, by each physician guided by his or her conscience.

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The questionnaire used in this survey is available from the first author.

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PRIVACY

Guarding medical secrets, at a cost

[Picture Omitted In Printing]

Doctors are withholding medical information from health records, and even lying, to help patients protect their privacy. In a new survey of 344 members of the Association of American Physicians and Surgeons, 87 percent reported that patients had asked them to exclude data from their records, and 78 percent had complied. Nearly one fifth admitted to making false entries.

Mark Schiller, a San Francisco Bay area psychiatrist and member of the AAPS board of directors, says that because of privacy concerns, he only takes basic notes about patients' condition and medications. Yet an incomplete or distorted record poses its own risks. He says he unnecessarily prescribed anti-psychotic medications to patients who had not divulged their cocaine or crystal meth habits. "I now have to balance privacy concerns with the need to communicate with other physicians," says Schiller.

– *Dana Hawkins*