ETHICS MAN **Daniel K Sokol**

When doctors deceive each other

Openness about deceptions that occur between clinicians can help us find out why they occur

In my mid-20s I spent three years of my life pondering the following question: "Can doctors ever justifiably deceive their patients?" The answer, in a word, was yes. Contrary to professional guidelines and modern codes of ethics, I argued that benevolent deception by doctors is, on rare occasions, morally permissible (*BMJ* 2007;334:984-6). Many readers were not amused. Some pointed to the guidance of the General Medical Council, which states that one of the cardinal duties of a doctor is to "be honest and open and act with integrity." Readers will not be amused at this article either, for it addresses a delicate issue seldom raised in the literature: doctors deceiving each other. To my deception sensitive eyes, there is an elephant in the hospital and I shall introduce it.

A doctor needs a computed tomography scan for his patient. To obtain the scan in good time he feigns concern about a possible pulmonary embolus on the radiology request form. He is also aware that, in the eyes of his consultant, a measure of his competence is how promptly and reliably he can obtain scans. Under interrogation by the radiologist, the doctor embellishes the truth to justify the urgency. An honest approach may have delayed matters. When asked about this practice the answer is usually pragmatic: "Everybody else is doing it." Such widespread manipulation creates a tension between two fundamental duties: the duty to be honest to colleagues and the duty to make the care of your own patient your first concern.

The embellishment to the radiologist may improve that particular patient's care, but it can also result in an unjust prioritisation of scans, with potential harm to other patients. The biased presentation can also lead radiologists to interpret the scans inaccurately, and this in turn can lead the referring doctor to provide needless and risky interventions. Leslie and colleagues have shown that inexact clinical information can adversely affect the computed tomography reports of consultant radiologists (*Br J Radiol* 2000;73:1052-5). What untold harm is caused by this deception? Is the system in a state of satisfactory equilibrium, or should it be changed? If the latter, how should we change it?

Some doctors use a similar strategy to get a patient seen at an emergency clinic or admitted to a particular ward. A doctor on a general ward calls the intensive treatment registrar and lies about the patient's previous quality of life to boost the probability of admission. It is only when the patient arrives on the ward that the truth emerges. Another doctor uses the same tactic to persuade surgeons to operate on a desperate patient. Once again, this may lead to injustice. The patients in greatest medical need may not get the appropriate care. And surgeons too can indulge in a spot of deception, telling the anaesthetist that the case will take only 30 minutes when it will clearly take longer or that an operation will be straightforward when it probably will not. In anaesthesia, an occasional deception occurs when the surgeon, struggling to operate during a difficult case, asks the anaesthetist to administer more muscle relaxant. The anaesthetist, whose monitoring tells him that paralysis is adequate, acquiesces and injects a dose of saline.

If failing to report something when there is a professional duty to do so constitutes deception by omission, then many doctors deceive occupational health staff by concealing their needlestick injuries. Out of fear or solidarity, doctors may also cover up a colleague's mistake. Many frustrated doctors have double checked, time and again, the actions of a substandard colleague, wondering whether a job was done properly. When teaching junior doctors I have been consistently surprised by how the efforts of some brave soul to report an incompetent colleague to seniors have been quashed. The "dangerous colleague" question is commonly asked at interviews for membership examinations, but when acted on in practice the outcome can be quite different. Another deception occurs when a trainee makes up a test result to save face in front of a consultant ("the blood test result is normal").

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Then there are those less serious deceptions to justify an absence from work or to provide a compelling reason to swap a shift with a colleague. There are those on job application forms, perhaps exaggerating a position of responsibility or inventing some audit that will tick an all important box; and those in the realm of publications, such as adding the name of non-contributing colleagues to articles before submission.

A medical student recently conducted an exploratory study on doctors deceiving doctors. It was geographically diverse and anonymous. The research ethics committee got nervous. The supervisor called the General Medical Council, which reassured him and the committee that it could not discipline the respondents if the survey was anonymous. Still, the response rate was extremely low, indicating perhaps that it is an issue that many doctors would rather not discuss, even anonymously. Fifteen of the 23 respondents said they had deceived colleagues.

So what should we make of all this? The immediate answer is that we should look at the situation more closely rather than avert our eyes. The focus has hitherto been on doctors deceiving patients and, to a much lesser extent, patients deceiving doctors. Despite the disapproving glares of unamused colleagues, we need also to be "honest and open" about the deceptions that occur between clinicians so that we can identify why they occur. Only then can we distinguish between those that are unjustified and need to be eliminated and those, if any, that are permitted.

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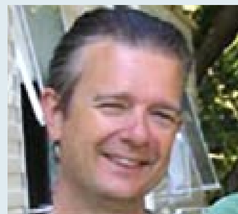
FROM BMJ.COM

US health care reform, and other blogs

JOHN MOORE/GETTY IMAGES

Vidhya Alakeson writes about the continuing effort to implement health care reform in the US, which has currently reached a standstill. "At the heart of this struggle to fix healthcare is a fundamental problem: most Americans have health insurance and they like what they have. Politicians have tried to convince the insured majority that they have nothing to lose and, in fact, a lot to gain from health reform. They do not appear to be listening," she says.



Martin McShane extols the virtues of using a safer surgery checklist. The National Patient Safety Agency set a deadline for this to be implemented by trusts, and it should already have happened. From talking to his surgeon friends he has realised how simple and effective it can be. "We discovered we had a 40% error rate in the first week. I've now implemented it in my private practice," one of the surgeons told him.

Julian Sheather writes about the problems of screening programmes. Some commercial purveyors of screening tests offer tests to people without making clear whether there is any correlation between the test and people's future health or whether the cure for any condition that might be identified is more harmful than the condition itself. "The increasing tide of direct-to-consumer health marketing looks to be bringing about a commercially-induced sea change in our understanding of health. Health becomes instead a permanently imperilled biological state that can only be maintained by means of expensive hypervigilance. It is health as paranoia, health as ceaseless anxiety," he writes.

Elsewhere Helen Jaques (left) asks what makes a good doctor, Richard Smith asks why the health service is so hopeless with domestic violence, and Emily Spry continues to blog from Sierra Leone.

Finally, David Payne keeps us updated with news from the Technology, Entertainment, and Design conference in California, and we tell you what the *BMJ* editorial team have been reading.

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Members of doc2doc, BMJ Group's online global community, are discussing redesigning the hospital gown

From DrS:
"The wrap round gown is all well and good, but gowns come into their own in that you don't have to roll/get the patient sat up to move the gown up/down to examine the chest and abdomen"

JulietHW joined in:
"I once had to be in hospital in a hospital gown, and frankly it was embarrassing. The gown was designed for someone much taller and larger then me, and I struggled to wrap it around me and fasten it in a sensible way."

Ghafa argues that a fashion designer should not be working on the redesign of the hospital gown:
"Why a fashion designer? I'm sure there would be someone out there who would design it for half the fee! Something that has those popping buttons on the front should do the trick. "

MATTHEW SHOPHOTOALAMY

AndyK defends the current version of the hospital gown:
"The design of the current gown is useful in that if you have a bed bound patient then little pulling around is needed to put one on if moving around. In the event of long term stay usually we have pyjamas or a nightie, which is better for covering up, but because of the amount of use, fasteners, poppers, and buttons tend not to last very long so half the time you can't do them up, they would be just as functional and still be free from the issue of troublesome broken buttons. "

tnolan also joined the defence:
"I don't see a huge problem with the ones we have at the moment. They're a sort of half wrap around at the top. As long as they're tied up you dont get any flashing."

Where do you stand? Have your say at http://tr.im/OgJk