opinion & debate

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Commentary: can deception ever be therapeutic?

The case Sandford *et al* (2001) reported is valuable insofar as it highlights some of the quite profound ethical dilemmas that arise in the ordinary clinical management of ordinary forensic cases. It is also interesting because it highlights some of the particular ethical dilemmas that arise in the context of long-term care. Many of the ethical dilemmas described in the bioethics literature relate to fairly short-term discrete clinical relationships, when urgent interventions are called for and short-term consequences dominate. In long-term care, care professionals have to engage with a patient as a person with a history as well as a present and a future; and this developmental perspective may well influence the process of ethical decision-making: processes perhaps best described by Agich (Agich, 1999).

The authors present their action as ethically justifiable; this is unsurprising, as otherwise they would not have carried out such an action! However, the fact that they have made a case for such an action to be ethically justifiable does not mean that there are not strong counter arguments that could be made against taking the same course of action. I think their case highlights the limitations of consequentialist arguments in bioethics, especially in the psychiatric context. In the rest of this commentary I am going to try and demonstrate what I mean.

One of the first points relates to the question of whether deception can ever be justified on therapeutic grounds. Deceptive practice in medicine has a long history (e.g. lying to the patient about prognosis or diagnosis, using paradoxical strategies or placebos). The justification already offered for deceptive practice in medicine is on therapeutic grounds, that is the wrong that is done to the patient by lying to them (and thus treating them disrespectfully) is justified on the grounds of possible benefit. However, it is important to consider that although there may be beneficial consequences, lying itself may cause harmful consequences to the patient. The patient may well feel upset and distressed when he or she discovers that he or she has been lied to, and harm may be done to any future trusting relationship between the doctor and the patient. There are also the unforeseen harms that the clinician may not anticipate; in such circumstances the clinician always assumes that the beneficial consequences will happen, but cannot anticipate what the negative consequences may be. A quick glance at the risk-assessment literature shows that it is difficult for clinicians to foresee future consequences. In ethical dilemmas it is common for clinicians to be biased in terms of foreseeing only positive consequences that they want to see because it justifies their actions.

Another problem with consequentialism in psychiatry is that it is not clear who gets to decide what a good

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consequence is. In a case like this, it is not clear why the clinicians alone are involved. The patient may have other carers who are involved and may like to express a view about the type of good consequence to be aimed for. Related to this is the classical argument against consequentialism, that if good outcomes justify means, then all sorts of possible harms and wrongs can be done to a patient in the name of those good outcomes. Concerns about the involvement of doctors in behaviour like this led to the development of various codes of ethics such as the Nuremberg and Helsinki Codes.

Another related issue raised by this case is when a living environment becomes therapy in itself. Again traditional consequentialist approaches to consent to therapy focus on short-term discrete interventions for diseases rather than disabilities. Consent therefore might mean something very different in the context of provision of 'aids to living', as opposed to medication or surgical intervention.

Lastly, in relation to deception, there is a very interesting view about the use of deception in forensic settings. Deception is arguably a form of social rule breaking. There is perhaps a particular poignancy about an ethical situation in which staff in a forensic unit have to behave dishonestly. Poignancy is heightened when one remembers that 'patients' who behave dishonestly are typically described as manipulative and deceitful, in ways that are often used as indicators of pathology.

Communication

I want now to think briefly about the question of communication skills in ethical dilemmas. Some ethical dilemmas may cause anxiety because sufficient time and skilled attention is not given to talking with the patient. For example, one wonders if it might have been practically possible to talk to the patient about moving over a period of weeks and months; perhaps by allowing her to develop a trusting relationship with someone who could listen and communicate with her about her anxieties. Her capacity to consent might have been significantly enhanced by communications made to her by carers; a point that has been made by many researchers looking at competence to consent. I was struck by the fact that prior to the move the patient was encouraged to make relationships with the new staff from the unit to which she was going to move. I wonder what would have happened if those staff, having spent several weeks on 'placement' and spending special time with the patient, had said to her "We like working with you very much; you have a lot to offer and a lot to gain from coming to live with us. Would you like to come and see where we work?" What I am getting at is that it might have been possible to get to the same point of getting the patient to actually visit the place without lying to her; I suspect that the chief objections to this were questions of time, which implied a financial expenditure in terms of allocation of resources.

Autonomy and long-term care

I want to consider the question of autonomy and long-term care. In long-term care settings it may be meaningful for consent to be expressed by proxy because patients may be dependent on others to make decisions for them. It is a long held principle of bioethics that respect for autonomy is a crucial aspect in doctor–patient relationships; however, this aspect may be complicated when patients' decreased autonomy is actually a function of their identity as a patient. I found myself wondering why so much emphasis was placed on this woman not living in long-term institutional care when she had been in such care from a young age, that is, it was very much a part of her history and development.

Sometimes it seems, as George Agich (1999) points out, that strength and independence are privileged as valuable over long-term dependence.

I have to say that I was not convinced by the justifications offered for the deception of the patient. It seemed to me that justifications one and three were essentially different variations on a consequentialist theme, that is, the deception was justified because of the awful consequences that would happen if she were told the truth. I wonder what would have happened if the clinicians had been wrong and the consequences had been negative. If she had refused to stay in a new placement, would her refusal have been respected or overridden? I wonder what would happen if the patient assented to staying in the new place, but seemed very unhappy and distressed; which consequence would have counted?

The other justification the authors offered was that the patient's dignity was respected by telling her an untruth. This is quite an unusual argument, and the authors did not provide much evidence for it; I am guessing that they would argue that the patient might be less dignified if she became distressed by being told the truth. However, this is not an argument that is generally applied to psychiatric patients; in mental health settings staff frequently do things to patients that distress them (such as giving forced medication), but we don't think that this necessarily reduces their dignity, or at least not enough to justify ceasing the action. The argument from dignity sounds good, but I wonder if it is really more a way of relieving the clinician's unease than actually addressing the patient's claims to respect.

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