LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital (MGH) sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. Such consultations require the integration of medical and psychiatric knowledge. During their thrice-weekly rounds, Dr Stern and other members of the Psychiatric Consultation Service discuss the diagnosis and management of conditions confronted. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Lies in the Doctor-Patient Relationship

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Have you ever lied to your patients or been surprised to learn that one of your patients lied to you? Have you considered it important to learn why lies emerge in the treatment relationship? Have you wondered whether (or how) you should confront such untruths? If you have, then the following discussion should provide the forum for answers to these and other questions related to the exploration, detection, and management of lies in the medical arena.

Clinicians realize that making an accurate diagnosis relies on the provision of reliable information by patients and their family members and that timely, astute, and compassionate care depends on effective bidirectional communications (between the patient and the physician). Unfortunately, both patients and physicians are often challenged by complicated communications; each group withholds, distorts, obfuscates, fabricates, or lies about information that is crucial to the doctor-patient relationship and to effective treatment. What doctors reveal, withhold, or distort matters greatly to their patients.[1] Such untruths and manipulation of information can damage relationships and compromise clinical care. Further, information exchanges are increasingly (via e-mail and medical records) electronic; fewer face-to-face interactions make communication even more challenging. Managed care and time constraints add further pressure. Additionally, doctors and patients are ever more encouraged to serve as partners in clinical care,[2] placing a greater demand on the relationship and on the open exchange of information. This article discusses acts of deception in medical settings and considers the context in which lies are told and how clarification and conflict resolution can occur.

WHAT IS LYING?

According to Ekman,[3] lying is the act of one person intending to mislead another, deliberately, without prior notification of this purpose, and without having been asked by the target. Such behavior includes efforts at both concealment and falsification. Verbal strategies of deceit involve the use of denial, distortion, evasiveness, fabrication, irrelevance, nonresponsiveness, and omission.[4] Using this definition, some psychiatric conditions—eg, conversion disorder (with the sudden onset of neurologic symptoms without any physically identifiable explanation) and confabulation (the automatic production of falsehoods to conceal memory gaps)—do not involve lying, as unconscious or uncontrollable motivations underlie symptom production. Similarly, the conveyance of false information when the individual believes it to be true, as in a dissociative or fugue state, or self-deception through unconscious defense mechanisms in the service of repression or as a manifestation of a personality disorder would generally fall outside this definition.

HOW HAS LYING BEEN VIEWED IN A HISTORICAL CONTEXT?

Intentional deceptions in the doctor-patient relationship can serve as obstacles to effective clinical care and can seem incongruent with the

benevolent practice of medicine; therefore, it is surprising to find some support for lies in the Hippocratic Decorum:

> Perform your medical duties calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him; sometimes reprove sharply and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition, for many patients through this course have taken a turn for the worse.[5(p297,299)]

Despite a lack of a clear prohibition of lying within such oaths, philosophers have long argued that lying is inappropriate. According to St. Augustine and divine law, lying is both illegal and immoral; it undermines relationships and the will of God.[6] Immanuel Kant argued (eg, by virtue of his categorical imperative) that because we cannot be certain of the consequences of our actions, lying in even the most seemingly justifiable circumstances is wrong.[6–8] Kant's premise was that truth telling is a moral duty[1] and that lies would eventually become self-defeating as people learn that they cannot rely on the word of others.[9]

Many historians and philosophers, however, have taken a less definitive position on deception. Accordingly, lying can be thought of as a normal part of human development (with confirmation that one's thoughts are independent and separate) and may even be adaptive in certain situations.[10] For example, utilitarians have viewed lying as more or less justifiable according to the goodness or badness of its consequences.[1] Similarly, the philosopher Sartre argued that there is no universal law to guide choices (eg, in matters of truth and deception).[7]

In the clinical encounter, views on lying vary. Within psychotherapy, Kernberg[11] viewed lies by patients as impediments to therapy. He suggested that untruths are indicative of a basic hopelessness about the availability of genuine relationships and that such deceptions can be aggressive assaults on the therapist and on the therapeutic process. Thus, lies by patients need to be confronted and challenged in an effort to attain authenticity in the encounter.

Others have viewed the withholding of information as a clinical aid, if not a duty. According to Korsch and Harding, "The information a doctor gives a patient should be tempered by who the patient is and what he or she is ready to hear."[12(p101)] In addition, many contextual variables—the doctor, the patient, the condition, the time frame, the need for privacy, the patient's expectations, the complexity of the condition, the implications of illness, and the nature of the interaction—influence the sharing of information. Accordingly, the kind of information a patient is given will make a difference in his or her attitude about illness, treatment, and overall health. In an 1871 graduation speech, Oliver Wendell Holmes concluded, "Your patient has no more right to all the truth you know than he has to all the medicine in your saddlebag . . . he should only get just so much as is good for him."[13(p388)] Similarly, Sokol[14] argued that benignly intended deceit of patients can be morally acceptable and provided guidance through the use of a decision algorithm.

The notion of the "little white lie" clearly establishes a hierarchy of deceit that sanctions some to lie in certain situations. However, Bok[1] questioned whether white lies are harmless. The deceived, for example, may not view the lie as harmless. In addition, failure to look at the context binds the liar to cumulative harms and to expansion of deceptive activities, while often sacrificing cost and public trust. Bok pointed to the commonplace use of placebos in clinical practice as an arena for the erosion of trust.[1] In fact, a recent cross-sectional analysis indicated that approximately half of all physicians acknowledge prescribing a placebo on a regular basis and that a majority of them believe that such practices are ethically permissible.[15]

WHAT TYPES OF LIES EXIST IN CLINICAL ENCOUNTERS?

Lies in the doctor-patient relationship are common.[16] Physicians often minimize problems, fail to tell the whole truth, or resort to overly simplified explanations. Two important arenas for potential omissions are the delivery of bad news and the admission of errors. Much of the discussion surrounding the delivery of bad news can be found in the palliative care literature. The task of delivering bad news is stressful; physicians who are ill prepared may either downplay the information, thereby misleading patients, or present it in an overly scientific, confusing, and sterile (nonempathic) fashion.[17]

Physician disclosure of errors is another minefield in the doctor-patient relationship. Physicians tend to provide minimal information to patients after medical errors and infrequently offer complete apologies.[18] In their review, Mazor et al[19] found substantial patient and public support for disclosure of errors. Physicians often support disclosure as well, although evidence suggests that actual disclosure rates are as low as 6%.[19] Similarly, Kaldjian et al[20] found a gap between attitudes toward disclosure and actual practices. In their survey, nearly all faculty and residents reported that they would disclose a hypothetical error resulting in major or minor harm to a patient. However, only 41% of those surveyed had disclosed an actual minor error (leading to prolonged treatment or discomfort), and only 5% had disclosed an actual major error (leading to disability or death). Most physicians cite concerns about litigation as a primary reason for nondisclosure, but evidence suggests that disclosure actually reduces the chance of adverse legal outcomes.[19,21,22]

Patients, on the other hand, may minimize or exaggerate symptoms or avoid key clinical issues. Malingering (the conscious simulation or feigning of symptoms for secondary gain) is another form of lying frequently found in forensic and clinical settings. Patients, for example, lie about symptoms to obtain disability or access to controlled medication or to avoid incarceration or other undesired legal consequences of their actions.

Psychiatrists and other health care providers are often called upon to assess the veracity of a patient's report. For example, a physician may be asked to make recommendations in the following scenario:

> A 34-year-old woman was admitted to the intensive care unit after being found unconscious beside 2 empty bottles of narcotics in a local hotel room. On examination, she had significant facial bruising. On interview, she stated that she had been in the area for a job interview, developed a severe migraine, and, too ill to drive home, decided to stay at a hotel. She denied having suicidal ideation/intent and provided future-oriented statements.

Whether one concludes that this patient was suicidal, was assaulted, or has a substance use disorder, such clinical decisions have a significant impact on treatment and on a patient's safety. Physicians are likewise called upon to assess a patient's statements (truths) about his or her sexual behavior and their adherence to recommended treatment, among others. In general, physicians often assume that a large percentage of patients fail to adhere to their treatment regimen and are reluctant to admit to such noncompliance. For example, a recent study showed that 30% of patients in a clinical trial of metered-dose inhalers intentionally "dumped" their inhalers as a way to feign compliance.[23]

WHY DO PHYSICIANS AND PATIENTS LIE IN CLINICAL ENCOUNTERS?

People lie for a variety of reasons,[24] including the avoidance of punishment, for preservation of autonomy, for aggression/power, for the delight of putting one over on another, for wish fulfillment, for furtherance of self-deception or repression of conflict, for manipulation of others, for the accommodation of the self-deception of others, to assert one's sense of self, to maintain self-esteem, and to solve role conflicts. In the clinical encounter, themes of exploitation, protection, and shame predominate. Physicians selectively use information exchanges as part of a therapeutic regimen.[1] Doctors cite reasons for limiting such exchanges and for not wanting to confuse patients, to cause unnecessary pain, or to eliminate hope. In such circumstances, the altruistic desire to do no harm may conflict with patient autonomy; it may be unclear whose feelings are actually being protected. In addition, physicians may lie to displace culpability for poor outcomes or to deny their ignorance or powerlessness to control disease processes.[16]

Physicians also lie to respond to intense competitive pressures. Lying may help a physician avoid interpersonal or intrapsychic conflicts or difficult topics (eg, talking openly about disability or death).[24] Prevarication may also represent an effort to encourage a particular treatment agenda. Sadly, there are also cases in which physicians exploit patients (eg, sexually or financially). Patients lie to avoid negative consequences, to achieve secondary gain (eg, to obtain medication or disability payments), out of embarrassment or shame, or to present themselves in a better light (eg, as dutiful and compliant). While the full spectrum of what drives a patient or a physician to lie is extensive, several schools of thought make important contributions to our understanding.

The Notion of the Ego Ideal

The concept of the ego ideal in psychology dates back several decades; it helps us consider the potential motivations for lying. The ego ideal, in simplified form, represents what people strive to be. It represents their yearning for (narcissistic) perfection and is unencumbered by environmental constrictions or by internal limitations. The ego ideal can be a vital source of hope, inspiration, and motivation. However, in cases in which the reality of life leaves people feeling either unsuccessful or insecure, the ideal version can be accessed to bolster a sense of power and worth. In its most harmless form, invoking the ego ideal can be manifest in lies about one's weight or performance on an examination. People simply want to be better than they are. The discussion by Kris[25] of personal myths is similarly illuminating, with a creation of a fictional narrative to protect the self from painful realizations.

Attachment Theory

According to attachment theorists,[26] truth is related to comfort with intimacy; intimacy requires the ability to seek and to give care, the ability to feel comfortable with an independent and autonomous self, and the ability to negotiate. Such tasks require comfort and a sense of security or trust with oneself and others. This includes the ability to tolerate and to maintain secure and positive representations even at times of discomfort. The need to be perfect often involves a defensive idealization of a self that fears retribution or rejection if an imperfection is found. If intimacy is perceived as dangerous, lies serve to conceal the true self in order to avoid destruction and avert a profound sense of shame. With ambivalent forms of attachment, a child (and later an adult) may believe that exaggeration of one's need is the only viable mechanism to obtain attention and care.[27] This exaggeration leads to the development of a narrative that may substitute desired truth for actual experience.

Neurobiologic Underpinnings

Cognitive and intellectual tasks involved in lying are complex; they include the ability to distinguish external from internal reality, the inhibition of the truth, the recognition of information that will sway others, and the ability to mask that one is being deceptive.[28]

Most of the research in this arena has been garnered from studies directed toward lie detection. Unfortunately, convincing evidence for structural or chemical factors that increase one's vulnerability to prevarication is lacking. Recent studies have looked to functional magnetic resonance imaging to identify neurobiologic markers associated with lying. Areas of particular interest have included the anterior cingulate cortex and the medial and ventrolateral prefrontal cortices, areas implicated in conditional learning, response inhibition, emotional processing, conflict resolution, and executive function.[29–34]

HOW CAN ONE DETECT LIES?

Most professionals are less skilled in lie detection than they think they are. In a landmark study, Ekman and O'Sullivan[35] asked representatives from various professions to determine if a woman on videotape was describing her emotions truthfully; these experts (psychiatrists, judges, police officers, and polygraph examiners) all performed no better than chance.

A wide array of strategies and technology to detect lies have been developed and summarized extensively elsewhere.[36] Of most relevance to clinical encounters, efforts have been made to identify speech patterns and facial cues that might lead to the detection of lies. A change in voice pitch appears to be an important indicator. Other aspects include slips of the tongue, emblematic slips (eg, shoulder shrug as an indication of helplessness or indifference), use of indirect speech and pauses (eg, circumlocutions, evasiveness, and offering more information than necessary), alterations in one's rate of speech, changes in breathing patterns, sweating, and an increase in swallowing.[3] Facial clues to lying include disguised smiling, a lack of head movements, certain motor behaviors (eg, scratching one's head), use of pause fillers, and use of less harmonic and congruent nonverbal behaviors.[37] Ekman[3] has described several facial features that are linked with not being genuine; these include blushing, pupillary dilation, false smiles, having asymmetric mannerisms, having muscle "leakage," squelching expressions, sweating, blinking, tearing, and blanching, as well as making mistakes in timing. Similarly, McNeill[38] identified 4 ways to tell if a facial expression is false (eg, with an asymmetry of facial muscles, with expressions that are maintained for more than 5 seconds, with inappropriate timing, and with forced false smiles).

Qualities of the person's report may also provide some clues as to one's veracity. Resnick[39] noted that some elements of a patient's report (including inconsistencies in the report and symptom presentation) may help identify malingering. Malingerers often are perceived as overacting to their illness, as being eager to discuss their symptoms, as showing more positive (eg, hallucinations) than negative symptoms (eg, apathy), and as having difficulty imitating a psychotic thought process.

WHAT ARE THE DOWNSTREAM EFFECTS OF LIES?

Lies in the doctor-patient relationship can have both immediate and far-reaching consequences. The experience of being deceived is often associated with complex emotions (eg, confusion, rage, betrayal, and despair). The deceived are also narcissistically injured; they may realize that they are not that important to the deceiver or that they were not savvy enough to have recognized the lie. Their trust in others and in themselves is violated. In addition, faith in one's neighborhood, church, and country can become suspect. People can become negative and cynical or feel so disenfranchised that they become avoidant (so as not to be wounded again). Lying also has an effect on the liar (eg, feelings of guilt, entitlement, alarming powerfulness, damage to a sense of personal integrity, and loss of credibility).[1,3]

Within medicine, physicians are often tempted to retaliate against patients who lie by withholding treatment. This retaliation can be particularly problematic when a patient lies to obtain medication or unnecessary entitlements. Also, failure to accurately detail a patient's condition and prognosis can lead to false hope.[40] Patients who feel betrayed often seek financial and legal retribution (eg, via lawsuits). Incomplete disclosure in both directions compromises clinical care. Lies that go unrecognized can promote misinformation or lead to treatment that is inappropriate or harmful.

HOW CAN LYING AND ITS IMPLICATIONS BE MANAGED?

While lying is common in many clinical settings, it is not clear if lying is universally bad or if it should always be addressed or confronted. Several unanswered questions remain. As technology improves, should patients be forced to submit to a truth test? Will toxicology screens be replaced by neuroimaging? Is lying like the proverbial tree in the forest, that is, significant only if it is recognized?

More important is to focus on the creation of an environment that fosters honesty. Here, the onus is on

physicians to take the lead. It is unrealistic to expect all patients to risk punishment, rejection, and humiliation without first setting a tone of tolerance, workability, and the capacity to accept ambivalence. Bok[1] challenged notions that patients do not want bad news, that truthfulness is impossible, and that truthful information is harmful. The whole truth may be out of reach, but it does not preclude speaking honestly with patients. Bok cautioned against making paternalistic assumptions of superiority that carry a risk of contempt. Thus, it is important to have more complex individualized decisions, with the burden on the practitioner to justify any concealments or withholding of information. Physicians can maximize truthfulness in the relationship by the following:

1. *Normalizing the tendency for patients and doctors to be reluctant to share information that may be painful or embarrassing.* For example, physicians can preemptively explain the tendency for patients to want to present themselves in the best possible light.
2. *Owning up to what is unknown.* For example, one can discuss openly the lack of long-term safety data for a particular intervention. Similarly, providers are best served by admitting when a particular issue is beyond the scope of their expertise and can offer consultation as indicated.
3. *Negotiating explicitly with a patient around the amount and detail of information to be discussed comfortably.* Physicians, for example, can be proactive with patients about potential dilemmas and barriers to honesty and explore how a patient would like those situations to be handled. Without making excessive personal revelations, a physician can disclose his or her own limitations and struggles at how to deliver bad news ("I want you to have a full understanding of the factors that impact your situation, but I am struggling with the best way to communicate this."); this disclosure will seem genuine and humane and will model honesty under difficult circumstances.
4. *Looking at truth telling as a process instead of an outcome.* The actual detection of lies, while important, does not preclude paying attention to the process of honest communication in the doctor-patient relationship.

Physicians are encouraged to rehearse different communication strategies and to seek supervision and consultation around matters that are challenging. While patients clearly have a role in fostering honest communication with their providers, physicians can best promote such interactions by being thoughtful, deliberate, and self-aware.

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