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The ethical foundation for honesty and the focused use of deception in dermatology

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Abstract

Physicians have a fiduciary duty to be honest and to act in the patients' best interest. There are times when these two duties conflict. Honesty is paramount in supporting the physician-patient relationship and loss of patient trust is devastating. Furthermore, even minor deception can suggest a return to the physician authoritarianism of the past century that has been decried by modern ethicists. Nonetheless, circumstances can arise in which good judgement may require less than complete honesty to avoid harm to the patient. If the benefit for the patient is large and the risk from deception is small, thoughtful application of minor deception could be designed to benefit patients. Of course, research is required to fully assess this strategy.

Keywords: ethics, deception, lying, truth, morality, adherence, psychology

Introduction

Deception is morally hazardous and can lead to adverse medical outcomes if patients lose trust in physicians. In addition, patients represent a vulnerable population in a uniquely dependent state. There may, however, be situations in which telling the full truth would adversely affect a patient's welfare [1]. This article describes the ethical framework that recommends honesty while considering narrow exceptions designed to benefit the patient for future dermatology research.

Moral Foundations for Honesty

Religious teachings have supported truth-telling for centuries. The philosopher Kant's categorial imperative forcefully argues for truth as a universal duty and strictly rejects lying as an evil harming human discourse and the dignity of every human person [2]. Physicians have further ethical obligations to respect patient autonomy requiring the provisional pertinent medical information so that patients can make informed decisions [3]. Even framing the truth or providing selected information is a subtle form of deception. When loss of trust is a possible outcome, the physician-patient relationship should be protected lest it impact the physician-patient relationship. In addition, it could be argued that the physician has no standing to judge the weight of harm caused by deception in clinical practice. Finally, the "slippery slope" argument suggests that a minor deception could lower the threshold for a larger deception or a return to 20th century authoritarianism in medicine.

Good judgment may include minor deception

Principlism is an applied approach to ethics that requires the medical profession to judiciously weigh

ethical responsibilities. Physicians have a duty to act in patients' best interest, following the ethical principles of nonmaleficence (the duty to do no harm) and beneficence (the duty to act for the benefit of others), [4]. A utilitarian perspective prioritizes the good of populations over the good of individuals. Doing whatever is best for patients, rather than honesty above all else, follows directly from a utilitarian ethical perspective (**Table 1**). This utilitarian perspective is expressed clearly in non-Western culture in which a wise physician is one who prudently applies intelligence to achieve societal or cultural goals. Although truth is valued, it is believed that truth could be tempered when "truth is bitter." Hence one may apply the saying, "it is not everything the eye sees that the mouth speaks" [5].

Discussion

Although lying and deceiving may be perceived similarly, a difference exists. Lying provides false statements whereas deception avoids this. Examples of deception include going along with an idea or withholding certain details [6]. Thoughtful application of minor deception could be beneficial in certain dermatologic conditions. Some areas where deception has been used are found in **Table 1**.

Delusions of parasitosis, also known as Morgellon disease, can be a challenging condition for dermatologists to manage. Although second generation antipsychotics such as risperidone and quetiapine are effective treatment options, they produce a social stigma. In fact, these patients are often reluctant to start antipsychotic treatment. Thoughtful deception can be used to improve willingness of patients to accept treatment for Morgellon disease. First, an infectious etiology of this condition has never been identified and Morgellons disease is associated with depression and other psychiatric conditions. Since second generation antipsychotics act on the nervous system, antipsychotics could target the infectious organism's nervous system while concomitantly managing the associated psychiatric conditions. Therefore, dermatologists can present the condition's concept that although the etiology is not well known, starting low-dose second generation antipsychotics are effective and relatively safe treatment options that act on the nervous system [7].

Also known as dermatillomania, psychogenic excoriation, neurotic excoriation, and excoriation disorder represent a similar challenging condition. Excoriation disorder was recently registered in the World Health Organization's International

Table 1. *Minor deception (framing the truth) designed to benefit the patient.*

Examples of Minor Deception	Comment
To encourage use of topical corticosteroids, the dermatologist states: "corticosteroids are a hormone from our body"	In the patient's best interest, this partial truth is designed to impact steroid phobia and improve adherence
Providing anecdotal evidence could improve willingness to start and adhere to a medication	Anecdotal evidence may suggest a medication works, while not mentioning cases where the medication was ineffective
Painting an image to the patient who will be starting a new psoriasis medication that they will be able to wear a sleeveless wedding dress after using the new medication may improve adherence	Salience is a technique that creates a vivid image in the patient's mind to influence their perspective of a new medication; even if it might not happen
Placebo medications are rarely used in clinical practice – for example, a low-potency corticosteroid may be prescribed to placate the patient's need for treatment	Physicians rarely use placebos and commonly use drugs of questionable value which may exhibit a placebo effect while "doing no harm." AMA ethical standard 2.1.4 argue against this practice without telling the patient the treatment is a placebo [3]
A study is designed using medication with a "memory cap" that records each time the patient opens and closes the medication to assess their adherence	An Investigational Review Board approved the study without informing patients of this digital monitoring since the value of the study was deemed important enough to permit this deception which would produce minimal harm to the patient. Of course, deception in research is different than deception in clinical practice

Classification of Diseases and Related Health Problems, revision 11, as an obsessive-compulsive and related disorder [8]. Although excoriation disorder is a psychiatric and dermatologic condition, patients may believe it is only a dermatologic condition. Therefore, patients with excoriation disorder usually present to the dermatologist first. Dermatologists can provide effective treatment options including selective serotonin reuptake inhibitors and lamotrigine [8]. However, patients may be unwilling to take selective serotonin reuptake inhibitors or lamotrigine since antidepressant and mood stabilizing medications are associated with a social stigma. Furthermore, patients are often reluctant to be referred to a psychiatrist. Although dermatologists could manage the underlying acne or eczema associated with excoriation disorder, control of the underlying psychiatric component is imperative to prevent irreversible damage. Therefore, dermatologists could use thoughtful deception to facilitate successful psychiatric follow-up.

Before considering the use of deception, Sokol recommends two "moral safety checks." First, could the deception be defended before a body of reasonable people, such as the ethics committee of a professional association, a court of law, or the public if it appeared on the front page of a newspaper. This is intended to reduce the risk of personal bias or self-deception in this judgment. Second, if the patient was aware of all the facts, would they likely consent to the deception [9]? The authors hope this brief article will encourage dialogue and focused research in dermatology about the risks and benefits of thoughtful application of minor deception designed to benefit patients as it has in other disciplines of medicine.

Conclusion

Blanket statements that deception is always wrong and ethically inexcusable may sound morally judicious and a great guide in the majority of situations. However, rigid rules may not result in the best medical care in every situation. Nonetheless, the ethical duty to be honest is not absolute; caring for patients is absolute [9]. While we wait for continuing research to guide us in this area, let us do what is best to advocate for each individual patient. We do this even if it is hard for us, while humbly avoiding the condescension of unrestrained authoritarianism.

Potential conflicts of interest

Dr. Steven R. Feldman is a speaker for Janssen and Taro. He is a consultant and speaker for Galderma, Stiefel/GlaxoSmithKline, Abbott Labs, Leo Pharma Inc. Dr. Feldman has received grants from Galderma, Janssen, Amgen, Stiefel/GlaxoSmithKline, Celgene and Anacor. He is a consultant for Amgen, Baxter, Caremark, Gerson Lehrman Group, Guidepoint Global, Hanall Pharmaceutical Co Ltd, Kikaku, Lilly, Merck & Co Inc, Merz Pharmaceuticals, Mylan, Novartis Pharmaceuticals, Pfizer Inc, Qurient, Suncare Research and Xenoport. He is on an advisory board for Pfizer Inc. Dr. Feldman is the founder and holds stock in Causa Research and holds stock and is majority owner in Medical Quality Enhancement Corporation. He receives Royalties from UpToDate and Xlibris. Dr. Robert T. Brodell has participated in multi-center clinical trials with: Genentech, Janssen Pharmaceuticals, Corrona Psoriasis Registry, Novartis, and Glaxo-Smith-Kline. Dr Adrian Pona, Dr. William W. Huang, and Robert H. Burrow have no conflicts to disclose.

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