

Lying, secrecy and power within the doctor - patient relationship

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ABSTRACT *From the basis of ethnographic material taken from two different fields, the author proposes the examination of two distinct situations referring to, in the first part the lying of doctors, and secondly the lying of patients. The first situation is that of medical practitioners, specialists in the treatment of alcoholism, who affirm to ex-drinkers that it is impossible to drink normally again after treatment, without falling back into dependency, whilst knowing of the existence of contradictory cases. The second situation is that in which a certain number of patients find themselves, in majority of Catholic or Muslim origin, who lead their doctors to believe that they have been taking their medication and dissimulate their real behaviour, that of non observance of prescriptions. These two situations are analysed with reference to the position of the author of the lie in the doctor-patient relationship. It is shown that lying, put into perspective with the notion of secrecy, is in this instance the expression of and the indication of a power relationship, and moreover that the rationalisation which accompanies the lie does not stop it from producing effects in contradiction to its motivation, showing, in the collision between therapeutic logic and social logic, the paradoxical character of lying.*

Introduction

From Hippocrates who deplored the fact that “patients often lie when affirming having taken their medication”¹, to Martin Winkler for whom: “To be a doctor, is to preach lying” (1998), lying turns out to be current practice in the relationship between doctors and patients. Justified, even legitimised in doctors, condemned in patients, as much by medical literature as by common sense, it is generally presented and studied from its moral aspects. However, beyond the ethical and subjective approaches to this question, highlighting the opinion that one can have about the achievement of a lie by a specific subject and in a given context, it is possible to study lying in the same way as any other social practice, in order to analyse, from an anthropological point of view, its mechanisms and social meanings.

The object of this article is to examine, from the basis of two field researches which were each undertaken over a period of five years, diverse types of situations, where lying, on the part of doctors and on the part of patients, can be seen, not in order to make a moral judgement of this practice but to analyse what is socially put into play when it takes place.

It will be demonstrated, on the one hand, that lying is in part constituent of the doctor – patient relationship, both a means and a sign of the power that each party derives from this relationship, and on the other hand, that this activity, as rational as it may seem in the sense that it has its ‘reasons’, sociological and/or therapeutic, is none the less paradoxical with regards to other logic which subtends the behaviour and the choices of actors.

Situation 1. Doctors’ lies

The first situation examined here is that offered by doctors who treat patients with alcohol dependency, and whose discourse I was able to record in the framework of a study of an ex-alcoholics association (Fainzang 1996). It could be expected that the question of lying in the context of treatment of alcoholics, would bring us to examine what the drinker achieves, when, renowned for the proverbial manner in which he promises never to drink again and whose word is widely reported through the

expression: 'alcoholic's word'. This is not the case. What interests us here, is the lie perpetrated by doctors for the attention of ex-alcoholics, presented in the form of an expert discourse, and willingly relayed by ex-alcoholics support groups themselves, at least when they want to be considered as the spokesperson for the medical point of view.

This is the case in the discourse which consists of affirming that it is absolutely impossible, for anybody who has been an alcoholic at some point in their life, to be able, one day, to drink alcohol reasonably, even a very long time after treatment, without the risk of relapse. The large majority of French 'alcoholologists'² insist on the fact that the consumption of even one glass of alcohol, causes the patients to relapse into alcoholism, and that abstinence must be total and permanent. The imperative of which it is the object is justified by medical research which has brought to light the prolonged risk to alcoholics of relapsing into a dependent situation linked to the damage to cell membranes, consecutive with their excessive past alcoholism. Even though the large majority of alcoholologists in France shares this point of view, it seems to be much debated on the other side of the Atlantic. American studies have established that a certain percentage of ex-alcoholics are able to drink in a 'normal' way several years after their cure (Antze 1987, Nadeau 1990). These studies have been denounced by those who consider them to be damaging to stabilised alcoholics, in the measure that, according to their critics, they risk tempting patients to try to drink again and consequently lapsing into the infernal cycle of the illness. I will not get into this controversy, as it is not the point here, but I will try to see to what extent one can speak about 'lying'. Beforehand, I will describe the context in which alcoholics can find themselves confronted with this type of discourse.

Support groups generally relay the medical discourse for ex-alcoholics even when the doctrine that they have on alcoholism (their theories on the illness) can be fundamentally different. Thus, an association such as *Vie libre* (meaning *Free Life*), radically different to Alcoholics Anonymous (particularly as far as its conceptions relative to the etiology of the illness and the notion of cure are concerned), never the less develop the same doctrine on the unavoidable relapse which follows when even a moderate consumption of alcohol is resumed. Although Alcoholics Anonymous considers the illness to be of biological origin and an individual problem, whereas *Vie libre* considers it to be of social origin and a collective problem, both of them agree with the affirmation that permanent abstinence is necessary³. The consensus among doctors and associations concerning the impossibility of drinking alcohol normally again is what brings them to hide (as I was able to observe) all examples likely to disprove this postulate. The following episode is quite eloquent regarding this. There is, in one of the *Free Life* association groups in the Paris area, which collaborates to a great extent with the medical world, the case of an ex-alcoholic who, after a drying-out period, has never completely stopped drinking and who, eight years on, drinks reasonably on a regular basis, and, it appears, is able to continue living normally, for his family life and the whole of his social relationships have stabilised. His wife and certain members of the group are aware of this but none of them discuss the matter. This man is a sort of taboo case about whom everybody keeps silent, and the allusions, which show that some members of the group are not, duped never lead to an open discussion, explicitly about his particular case. Everything happens as if they were careful to not question the fundamental principal of the fight against alcoholism, even though the group does not restrain itself from speaking openly with regards to any real relapse. Yet in this case, there is no relapse. This ex-alcoholic is a counter-example to the model of abstinence diffused by *Vie libre*. His case is subversive because it disproves the postulate on which the (therapeutic) militant action of the movement is based. The difficulty that exists in admitting that he continues to drink is on a par with the will to continue spreading the equation: one drop = relapse. If nothing is said about the case of this man, it is because it questions this equation, and the belief in its validity for all is necessary in order to cure the majority. The way in which the group manages the case of this person reveals the fact that this type of association cannot permit such dissidence, that could undermine the foundations of its doctrine and its militant activity against alcoholism, and that could make the abstinence willpower waver in many weaned alcoholics. Whereas relapse does not question the doctrine but rather confirms it, moderate consumption of alcohol endangers the theory of the illness and cure developed by the group. In fact what we are seeing here is simply the adoption of the medical discourse by an association, which takes charge of the patient and claims a part in the therapy.

But let's go back to the doctors of whom the association is up to a certain degree a spokesperson. It could be thought that it is a simple matter of a conviction on the part of doctors, and that the opinion

that they have of this matter does not make it a lie. With regards to this, we will distinguish along with Simmel (1964), lying from false belief or error, and will agree in saying that lying does not only consist in saying something untrue. For his word to be a lie, the speaker must know that it is untrue, and that it is produced in order to make the person to whom it is destined believe it. That is exactly what it is here. In fact, what is particularly striking is the use that doctors make of the knowledge they have of cases such as the one mentioned earlier. They state: "It is true that there are cases where normal consumption of alcohol is possible, but this *should be kept secret!*" and suggest: "don't tell them that it could be possible; they must believe it to be impossible!" Therefore it must be loudly proclaimed that moderate consumption is impossible, even if this is not always true, so that patients will not believe that it is accessible to them.

The lying undertaken in this instance by members of the medical profession (as well as by associations for ex-alcoholics who relay their discourse) is linked to the danger (on a therapeutic level), which the statement of truth contains. It is justified by the performative character of the statement of truth since, for alcoholism specialists, to state that it is sometimes possible to drink again, one day, equals an invitation to start drinking again. It is for this reason that doctors refuse even to bring up cases of patients who seem to depart from this rule. It is a strategic lie within the framework of therapeutic activity. It expresses a position of power, even if it has a beneficial and positive aim for the patient. Doctors use their position of power (and the knowledge attached to it) to produce a discourse where the truth is deliberately hidden from the patient.

Situation 2. Patients' lies

The second situation is brought to light on examination of the social behaviour of patients, for all types of pathologies, during consultation and, more generally, in the doctor-patient relationship. During research into social behaviour with regards to medical prescription, medicines and doctors, of patients from diverse cultural origin (Fainzang 2001a), I noticed that a certain number of patients lied to their doctor. This lying has several forms: For example, the patient claims to have taken his medication, when this is not the case. In fact, it is not rare, when treatment does not suit the patient, for him to not discuss this with the doctor but to decide in secret not to follow it, going as far as confirming the contrary, during a later consultation. Or it may be that he hides the fact that he has already tried another treatment, maintaining that he has not taken other medication. This is mainly the case when the treatment was undertaken in the instance of auto-medication that is without medical advice or in instances of homeopathic treatment, when the patient knows or supposes that his doctor is not convinced of the efficiency of this type of prescription and that he would be displeased with such a practice. Certain patients confided to me that they used auto-medication or homeopathic medication, also even alternative therapies such as those offered by faith healers but, feeling guilty of transgression, asked me not to speak to their doctors about it. The fact of deciding, on the part of a patient, not to tell his doctor that he has already taken prior treatment or chosen to undergo different therapy is a dissimulation (a constituent element of lying) which has of course a link to secrecy, because it was revealed to me in confidence. I will come back later, in the discussion, to the relations that lying maintains with secrecy, whilst distinguishing itself from it. 'Not to speak' and 'not to speak the truth' are distinguished from each other through the content and the objective. Nevertheless, it will be shown that one can become the other. Everything occurs as if, in each case, the patient committed a blameworthy and guilty act, liable to the anger or disapproval of the doctor and that it should be hidden from him. The medical doctor embodies an authority that may be lied to (hidden the truth or told the falsehood) to escape from its wrath, avoid conflict, criticism, or blame.⁴ This submission to the doctor, particularly the family doctor, was at the root of the anxiety of a woman whom I met for the first time during a hospital stay, and who I asked if I could visit her at home at a later date to discuss her way of dealing with her illness. Before giving me a favourable response she enquired: "My doctor won't be angry with me if I speak to you, will he?"

Studies, which aim to look into the relationship between the doctor and the patient, have underlined the conflict that sometimes exists between the two, a conflict, which the interactionist school analyses to be the result of a divergence of perspectives and interest. However this conflict does not always express itself in the same way, and the patients' cultural characteristics certainly have some

relationship to their modes of expression. The cultural dimension, inferred through any religious belonging or origin, crosses other dimensions, in such a way that it is not possible to apply indistinctly, to all the subjects of one social group, the same behaviour model, any more so than we can put down to the individual or psychological level what is undoubtedly dependent on collective tendencies. So, it appears that certain patients are more inclined to hide from their doctor their refusal to follow his prescribed treatment or hide their alternative remedy, and pretend to be observant of prescriptions. Enquiries conducted in diverse social and cultural environments reveal that, generally, lies told by the patients to their doctors concerning the manner in which they follow prescribed treatment, is more common in working classes than in privileged milieus and, above and beyond their social situation, by patients of Catholic or Muslim origin, than by patients of Protestant or Jewish origin. As I have shown elsewhere (Fainzang 2001a), lying and hiding the truth are linked to a stronger submission to the doctor in the first than in the second groups, of an equal social background. However this does not necessarily imply a greater submission to prescribed treatment nor a better adherence to treatment: it does not in fact necessarily signify taking that which the doctor prescribes, but it implies not telling the doctor of their refusal to follow prescribed treatment. It therefore shows a different relationship to the authority that it embodies. Numerous are Catholics, from different social backgrounds, who do not want to risk setting the doctors against themselves and for this reason do not take the risk of irritating the doctor by refusing his prescription. In the same way Muslim patients always maintain that they have taken the treatment even if they have stopped⁵. In fact, submission seems to be an important value in Muslims: the name itself (Muslim, *moulim* in Arabic, means ‘submissive’, from the word Islam which meaning is submission). The behaviours in Muslims are linked to certain indistinctness between social rules and religious rules: “the Muslim *Tadiths* dictate behaviour”, explains an imam who compares the religious law to the constitution and the *tadith* to the *Journal Officiel* (Official Gazette). The learning of submission is not only the political behaviour to which one can legitimately think that individuals are trained when they have lived under a repressive regime. It is also that which is taught by a religion or a culture. People of a Muslim origin who are non believers behave in the same deferential way with regards to the authority of the medical profession and do not go against its opinions by keeping to themselves the fact that they may not want to take such or such medication. A sociologist of Muslim origin, non-believer, whose father was a civil servant in the French administration system, and a graduate of Saint Cyr, who had a stomach ulcer and who is today treated for osteoporosis, always takes the drugs prescribed by her doctor, but stops treatment if the side effects are unpleasant. In this case she never tells the doctor, fearing that she would be considered to making fun of him or being impertinent to him, and she justifies it: “It’s true that if we go to see a doctor, it’s not in order to tell him afterwards that we don’t want to do as he says!”...

Lying is therefore a means of dissimulation through fear of blame. If it expresses a form of resistance to doctors and their prescriptions, it is not affirmed as such, but shows on the contrary a state of submission. It is the expression of a dependent relationship with regards to an authority in the face of which one does not dare to openly show resistance or refusal. Here, lying is accomplished in the framework of a power relationship where the one who practises it is dominated, expressing both submission and resistance to this power. We will show that lying is present in many other situations and that it is diversely justified (rationalised) by their authors.

As we can see, these two situations are apparently completely different, but have in common a certain number of elements, which could be deemed structural, with regards to the links between lying and the exertion of power. Before a more in depth examination of the nature of this link, we will refer to existing ethnological literature on secrecy to see in what way and to what extent lying is connected to it.

From secrecy to lying

We cannot look into the question of lying here without leaving a space for secrecy, if only in order to underline not only the connections maintained by the first with the second, but also the differences which exist between them, in other words to see what is specific to lying, what it means and what it produces over and above the unavoidably secret dimension that it contains.

Authors who have looked into the question of secrecy have shown the links that it maintains with power (Augé 1974, Zempléni 1976, Jamin 1977, Duval 1985). These studies have provided striking analyses in so far as they have stressed the power, which is implied by the fact of not saying something itself. The alliance between power and speech is a general phenomenon of social functioning. In this respect, power can be as much refraining from speech as speaking. Clastres (1974) showed, with reference to the Indians, that exertion of power is in fact use of speech). However, the social law merges particularly with a law of silence, after which the power strategy is to keep silent (Augé 1974). This is why Jamin adds that exertion of power is also a gaining of silence and that power can only be acquired and maintained by appropriating and holding back speech. According to him, the links between secrecy and power are objectified in the fact that the importance of secrecy resides less in what it hides than in what it asserts: belonging to a class, a status.

If secrecy is connected to silence, lying is for its part as much hiding the truth as saying the falsehood. One measures all the difficulty to distinguish between the cases where something is not said in order to not disclose it and where something is not said in order to lead to believing the contrary. In both situations presented above, the border between secrecy and lying is tenuous. In the first one, lying is the exertion of power and holding back knowledge: the doctor jealously keeps a secret vis-à-vis a person who is dependent on him. Looking into the dealing of knowledge versus its vulgarisation, Roqueplo (1974) has shown that holding back knowledge was the protection of one's own place in social hierarchy and that sharing knowledge was sharing power. In the second situation, lying is the exertion of a counter-power (dissimulation being here resistance to the doctors' power).

While, in the political and religious fields, secrecy is generally looked at from the angle of its social function, namely as it comes under a mechanism of holding back information connected to the exertion of power, in the medical field, secrecy is generally seen as silence on the part of the doctor with regards to what concerns the patient, for the benefit of the latter. A certain number of authors underline the necessity to conserve secrecy as a fundamental value of the individual (Coll. 1996). Secrecy is valued in so much as it enables identity to assert itself in the face of otherness, to preserve intimacy, to protect the individual, in short, "to preserve a part of freedom in a democratic society, in rebellion against the phantasm of absolute transparency proper to totalitarian societies" (Maheu, 1996). It is also valued as the key to trust that must exist between doctor and patient and which is the foundation of 'medical secrecy' or 'professional secrecy'. Medical secrecy concerning the patient is a fundamental value of society, and its transgression is condemned by law (cf. René 1996 about article 226-13 of the new penal code).

If medical secrecy is different in this, that it doesn't aim to produce false information, it nevertheless aims at withholding information, at keeping it from others. Secrecy is therefore conceived as a means of protecting the patient so that he doesn't suffer from the fact that others know this information. Patients themselves can choose to disclose or not their situation. Carricaburu & Pierret (1995) looked into the consequences that not revealing HIV status in individuals could have on everyday life. In this case it is a question of keeping the secret in order to be able to live as normally as possible, taking into account the stigma attached to AIDS. Moreover a huge amount of literature exists, as much for occidental societies as for African societies, on the subject of keeping information from others (close or not) in cases of AIDS, where secrecy can be used to exclude or on the contrary not to be excluded (Dozon & Vidal 1993; Gruénais 1993; Radstake 2000). In these cases, medical health professionals and patients share the secret about the diagnosis, which creates a link between them.

However, secrecy is not only hiding from others the state of health of the patient. It is also dissimulating from the patient himself the reality of his state of health. It is therefore not only a matter of confidentiality and discretion for the benefit of the patient, it is also, like lying, the holding back of information, of the truth, from the patient, which is of more interest to us here, because it is this last case which says something about the doctor - patient relationship. Secrecy becomes lying as soon as it is a matter of keeping the truth from the patient. This is what happens in the case that Higgins reported (1986) when a doctor to whom a colleague asked if he had revealed the nature of his illness to the patient or if he had preferred to keep it secret, answered: "I lied without hesitation, I said 'no, it is not cancer'". In this case, secrecy shows, in the same way as lying, the distance between the doctor and the patient. It does not tie the patient and the doctor together, in the face of others, but it separates

them from each other. The links between secrecy and lying are woven by the existence of a common antonym: truth. The alternative: tell / not tell ties up with the dyad: tell the truth / tell a lie.

Lying cannot be confused with secrecy, in so far as there is, in lying, a more active dimension. (For Simmel, not saying and lying are the passive and active forms of secrecy (Petitat 1998). Secrecy and lying maintain nevertheless reciprocal inclusion links because secrecy can imply lying and lying entails secrecy, in other words it implies keeping the truth secret. In this respect, lying must be regarded in a conceptual framework in which it is seen at the same time as distinct from and connected to secrecy.

Secrecy with regards to the patient from whom information about himself is hidden, is closely related to lying since it consists in deceiving the patient about his true state of health. This lying is justified by a rationalising discourse, which makes it legitimate in the eyes of some doctors. The invoked reasons are diverse: Some speak of the refusal on behalf of the patients to know the truth, or their fear of the truth, others evoke the harm that the truth could cause to them. Numerous works agree to morally justify doctors' lying. With regards to this, Plato (1966) wrote, in *The Republic*, that only doctors and city leaders were allowed to lie, the first in their patients' interest and the second in the interest of the city⁶.

The close links that exist between secrecy and lying clearly appear when they are seen as a means of exercising power or controlling the behaviour of others. When H. Arendt (1972) talks about secrecy as a means to govern, she includes "deception, deliberate falsification and pure and simple lies, used (by the dominant) as a legitimate means to realise (political) objectives". However it is noticed that, if it shares certain characteristics with the lying undertaken by those who have political power, lying on the part of doctors has the particularity that it is 'whitened' ('white lie'), rationalised, legitimised or even ethically founded. Though it is a tool used in the service of medical power, the idea is that it is a lie to benefit the deceived and not the deceiver, contrary to what goes on among politicians (of which the archetype is Machiavelli). The notion itself of 'pious lie' is obviously fitted to detract from its negative value. The lying of doctors is typically inscribed in utilitarian philosophy, which legitimises it on the basis of its useful consequences. For advocates of utilitarianism, the justification of an act weighs up the positive and negative nature of its consequences. In utilitarian philosophy, the choice of lying is therefore made after calculating its risks and benefits. On this point, Bok (1979) underlines, in her moral philosophy work, the highly relative character of the so-called reasonableness of lying or of the damage caused by truth: to not tell the truth is better for whom? she asks, highlighting the subjective dimension of judgement, with regard to the supposed innocuousness of 'white lie' or 'noble lie'. She challenges the notion of 'noble lie' for it supposes that only the powerful know what is good for others, and that they consider the deceived to be incapable of having an adequate judgement of their situation, or of responding in an appropriate manner to truthful information.

However, unlike S. Bok, I am not trying here to judge the validity or not of lying but to decipher what is put into play, socially, with its use. My point is not, for all that, to adopt a relativist perspective as if it was a matter of minimising the negative character of lying, by saying that, in certain circumstances, it is not seen as such and is not a real lie. This type of approach is that which Armstrong (1987) adopts whom, in a diachronic perspective, considers that "a lie only exists in relation to a regime of truth which enables it to be identified as such". He reproaches Ariès for considering the practice of hiding the prognosis of imminent death from a patient, which dominated the period of time from the middle of the 19th to the middle of the 20th century, to be a lie. For Armstrong, instead of condemning this period for its silence and holding back of the truth, the question should be if that which we consider to be a lie today was a lie at the time. He considers that, in the process of transformation from one regime of truth to another, several stages exist, of which the first is precisely recognising if silence can be constructed or not as a lie, underlining that this is a social and historical construction. Other authors, who, on a synchronic level, put forward, following cultural relativism precepts that lies that are acceptable in one society may not be in another, have also adopted this perspective.

Nor will we accept Hackings' nominalist perspective (1982), which takes up Hamlets' maxim on good and evil, and transposing it onto the question of truth, says: "Nothing is either true or false, but thinking makes it so". A perspective which is adopted to a certain degree by Henderson (1970), for whom it is not possible to tell the whole truth to patients, but who refuses the notion of lying on the

motive that: “Because telling the truth is not possible, there cannot be a clear distinction between what is true and what is false”.

Doctors themselves nevertheless evidence the practice of lying: “We sometimes tell lies. Yesterday, I lied to a patient suffering from lung cancer with metastases”, declared D. Khayat, head of an oncology department (Favereau 1994). Some admit that it is a lie: “Frankly speaking, it can happen that we tell a barefaced lie to the patient”, declares S. Merran, a radiologist scanner operator; whereas others hide behind the affirmation that it is not a question of a lying but rather a question of not saying the truth (R. Brauman, president of *Médecins sans frontières*, says: “I don’t lie, but sometimes keep back the truth through necessity”, while some others lie by manipulating words. S. Merran clears himself from lying by bringing up “the attitude which consists of not lying but of not mentioning the word *metastasis* either (and saying): ‘there is a small thing on the lung’”. The negative image of the term ‘lie’ is what makes us loathe using it to describe doctors’ behaviour. The use itself of the notion of ‘pieux mensonge’ in french (= pious lie) aims at ridding itself of this negative image, which is not shared with the terms ‘silence’ or ‘secrecy’⁷.

However, if we rely on the definition that Warren Shibles (1985) proposes, and according to which lying is believing or knowing one thing and saying another, one should admit that doctors ‘lie’ to patients. Seen from this angle, secrecy like silence is the masks of lying. Not only do the diverse forms of justification or relativisation not take away from the lying of doctors its nature of lying but also these forms themselves are exemplary of the social position that the doctor’s lying assumes in the therapeutic relationship⁸. In fact, secrecy and lying are connected in different ways according to whether we take into consideration the author of the lie or the person that is lied to, the place of each in the game of social relationships (including medical relationships) and the motivations or social reasons that structure it. It is obvious that the value of or the condemnation of lying is dependent on the context in which it is produced: the context gives a particular valence to lying since it is usually considered as positive when it is undertaken by the doctor, and as negative when it is undertaken by the patient. The lying of the doctor comes within the framework of permissible lying that of the patient does not. If it is true that, as Simmel suggests (1964), all social relationships imply a certain amount of reciprocated dissimulation, this dissimulation is not considered in the same way according to the position held by the protagonists of the relationship.

Lying and power

Depending on the position held, it is therefore seen that the lies told by doctors do not have the same meaning or function as lies told by the patients, although doctors and patients both express their specific position in the relationship which unites them. On the side of the doctors, the exertion of power within the doctor-patient relationship is expressed in an exemplary manner through the appropriation of the patients’ body. Numerous doctors claim the privilege of knowledge concerning the patients’ body and have a tendency with this aim of not disclosing information susceptible of enabling him to make his own choices concerning his being. It is striking to note that this appropriation concerns more Catholic than Protestant doctors (Fainzang 2001a), an observation which partly concords with that of Gordon (1991). Deborah Gordon speaks about the cultural basis of this practice, which consists of not stating and not recognising a diagnosis of cancer. Contrary to practice in North America, she notes that in Italy there exists a cultural consensus surrounding the fact of not telling the truth regarding this subject: it is current practice in Italy to not inform cancer patients of the diagnosis concerning them.

However, the question of doctors’ lying does not come down to revelation of diagnosis. We have seen this in the previous example (situation n°1), but it can be seen in many other cases. If some doctors only give information to patients with the view to enabling them to make a decision which conforms to their opinion, and therefore to obtain their own therapeutic objectives (cf. Katz 1984, who notes that this information only concerns the benefits and risks of a proposed treatment and not alternatives to the treatment), it isn’t rare for doctors to retain information even about the risks involved in a treatment with a view to inciting the patient to follow it. Some doctors choose to say nothing about the possible effects of treatment, and even to discourage patients to read information leaflets (“you read too much!” they tell them), so that this information does not risk dissuading them

from taking the prescribed treatment⁹. Other doctors go so far as to contest information contained in pharmaceutical leaflets, so that the patients comply.

Whether they affirm the impossibility of normal alcohol consumption one day for an ex-alcoholic, or invalidate the information provided by pharmaceutical laboratories on the possible side effects of some drugs, which are recognised in the information leaflets, doctors produce a discourse, if necessary untrue, in order to achieve their goal. Generally, the patients do not question this discourse. The aura of truth which surrounds medical discourse is linked to what Foucault (1980) calls “the political economy of truth”, one of the characteristics of which is to assume the form of the scientific discourse and the institutions that produce it¹⁰.

Lying therefore holds, like secrecy, a decisive place in power relationships. We will refer on this point to Barnes (1994) who, citing diverse studies on the subject, recalls to what extent lying plays a role in the establishment of dominant relationships, notably in the political field. However, the authors that he mobilises for his argument view lying in the frame of an explicit power relationship and not in a therapeutic relationship. Besides, some authors tend to view this in a unilateral manner only: the lying of the dominant. Yet, the reasons for patients’ lying are not the exertion of power but the exertion of resistance to the power of others. The fact that telling both can practise lies equally the dominant and the dominated, or the weak and the strong, as is the case in the Sunnit community in Akkar (North-Lebanon) studied by Jamous (1993), does not invalidate its structuring role in a power relationship. Lying is at the same time the expression of and the condition that strengthens this power. As in telling the false or keeping back the truth, lying can express as much the exertion of power as the hidden resistance to this power. As shown, this reflection cannot be reduced to the simple exposure of medical power. The problematic of the links between power and lying must also enable understanding of the latter as the expression of the power of the actors who, through their actions, possibly signify their power of resistance to the power of others.

Nevertheless, if on the part of the patients, lying shows resistance to the doctors’ power, it is hidden resistance, a refusal of open opposition. In fact, while affirming a form of power through their actions — non-observance, non-consumption, or other diverse recourses (alternative therapies, auto-medication, etc.) —, they reinforce at the same time their position of submission to the doctors’ power through their lies, as it is (or as they believe it is) impossible for them to affirm or claim credit for this resistance¹¹.

Considering the use of lies told by patients of Muslim origin, one could cede to the temptation of a culturalist analysis in thinking that this stems from a ‘cultural’ practice, following the example of what happens in Malaysia¹², where lying can be a form of politeness, and where it is incorrect to say ‘no’ (hence the decision to reply always ‘yes’ even if it is false). This temptation would no doubt have been strong if enquiry had revealed that the lies formulated by patients regarding the way they took their medication was only observed in patients of Muslim origin, and the risk would have been to conclude that there exists a cultural tendency to not voluntarily contradict one’s interlocutor, such as was precisely stated in the case of the Semai of Malaysia (Dentan 1970). But the fact that I also observed this behaviour in Catholics, and that both Muslims and Catholics have the common characteristic of manifesting, on numerous levels, submissive behaviour with regards to doctors, gives this lying a particular dimension and makes it subject to a different analysis, more attentive towards social relations and in particular towards the power relationships between doctors and patients. Challenging then the culturalist approach to lying which would consist in saying that it is not admitted or perceived in the same way according to different cultures, I see the use of lying by patients as being induced through a power relationship (including fear and submission), and a specific relation to authority.

While with the doctors’ lie, the aim is to produce something, to establish a behaviour pattern (abstinence, taking medication, etc.), with the patients’ lie, the aim is, in a symmetrically inverse manner, to prevent something: the reprobation of the doctor. We therefore find ourselves facing two situations where the subject is put into a position of lying, in the first instance because he has power, and in the second because he hasn’t.

Lying and paradox

We will come back here to the question of rationalisation of lying in order to examine to what extent this notion can distinguish doctors’ lying from patients’ lying. As we have seen, lying is rationalised

when it comes from doctors (it is then said to be employed for the ‘benefit’ of the patient). On the other hand, it is considered to be irrational when employed by patients: it harms treatment and cure for it hides from the doctor information that is necessary to carry out his job. It is necessary to split from this division and to admit that it is not more rational on one side or the other. Not only because patients also have their ‘reasons’ for lying, but also because lying is, in both cases, governed by cultural reasons and not only utilitarian, functional or rational and that the first are susceptible to take over from the second.

Among the rationalisation types, which subtend doctors’ lying, we can mention the usual statements or questions asked: Is the patient ‘able’ to hear the truth? What will his reactions be when faced with it? What will the psychological consequences be? What will he do with the truth? What will the consequences be on his behaviour? Finally, here lying is justified by the idea that the truth is not appropriate for the person who is lied to. In this respect, a large difference between doctors’ lying and patients’ lying is that the rationalisation of the first is accompanied by its moral justification (to not cause harm, help towards the cure, etc. (cf. Henderson [1970] on the “disastrous consequences of the truth”), while if patients also rationalise their lies (to not upset the doctor if he learns the truth, to not run the risk of criticism), this rationalisation is not accompanied by any moral justification. On the contrary, the patients feel guilty, and when they do take the doctor into the confidence or admit their faults as sometimes happens this experience takes on the appearance of a confession.

Of course as a counterpoint to the rationalisation of the lies told by medical health practitioners (and that have a justification value), diverging positions exist, such as those of D. Sicard (President of the National Ethics Advisory Committee in France), who challenges the concept of ‘useful’ truth or ‘contestable’ truth, “as if there were a sort of variable-geometry opportunist code which is perhaps the height of what medical paternalism is reproached for” (2000), or B. Hoerni (1999), who lays down the necessity of informing the patient as the respect due to the person’s autonomy.

However, rationalisation of lying on the part of doctors is largely achieved both in the medical discourse and in the common sense discourse. It is brought to light through certain official ethical and deontological texts, which legitimise its use. So the French professional code of medical ethics makes the provision, in article 35, that “(...) in the patients’ interests and for *legitimate reasons* that the practitioner appreciates *in good faith*, a patient can be *kept in ignorance* of a serious diagnosis or prognosis (...)” (underlined by me), whereas the Declaration on the promotion of patients’ rights in Europe, WHO, 1994, stipulates, in Art. 2, that: “patients have the right to be fully informed of their state of health, including relevant medical data, possible medical acts with the benefits and risks involved and alternative therapies (...). Information can only, in exceptional circumstances, be *kept from the patient* when there are *good reasons to think* that it could be seriously damaging to him”.

Yet, as rational as the practice of lying on the part of doctors can be, it is nevertheless paradoxical¹³ with regards to the objectives affirmed by the medical profession, that are, to operate (“in the interests of” and “for the good of” the patient) for the “patients’ *education*” or the “patients’ *information*” or to obtain “*informed*” or “*enlightened*” consent. The use of lying as a risk prevention technique in the case of alcoholism, or as a means to oblige the patient to comply with medical prescriptions, does not concord with those professions of faith in favour of the patients’ accession to education, information or enlightenment.

Likewise, patients’ lying is paradoxical in this way, that not only does it go against the doctors’ therapeutic objective from whom he expects efficiency and into whose hands he places his body and fate — by behaving in a manner contradictory to that of willingly allowing the doctor to carry out his role efficiently —, but it conveys and reinforces at the same time his subordinate position in the face of medical authority.

Conclusion

This article has proposed a reflection on the sense, the use and the role of lying in the doctor/patient relationship, its meaning and its social implication. The analysis of its forms of use brings to light not only the social relationships in which the protagonists are inscribed, but also the collision between the diverse logics in which it is founded. If we have been able to show that, in lying, each participant was affirming his place in the power relationship between doctor and patient, and had a reason (even a rationalisation) at the basis of his lie, it is, however, noted that this goes against another form of logic,

which is in a certain way antagonistic. In lying, the subject reinforces the power relationship, in which he goes against that which he professes: The doctor in the face of information and of obtaining enlightened consent, and the patient in the face of his freedom to choose. Although the subjects are apt to rationalise their acts, these offer a paradox in the measure that they are governed by diverse reasons (material, relational, symbolic), other than strictly therapeutic, which lead them to lie. Lying appears to be a product of the doctor-patient relationship, which evades the only therapeutic reason¹⁴ because it is subtended by cultural and social logics.

This leads to questioning the affirmation according to which the actors always behave in a conscious and reflective manner. Of course, lying is part here of a deliberate process, integrated into a strategy for which the subject can develop his reasons, or a rationality. However, can we conclude with Giddens that “a person is an agent who gives himself aims, who has reasons to do what he does and who is capable of expressing these reasons in a discursive manner (including lying)” (1987: 51)? If they know the reasons for their acts, are actors always aware of what founds them? Do they see the trace of exertion of power for some, or of submission to medical power for the others? Do they see, as this analysis has shown, the discrepancy that exists between the reasons for and the implications of lying and, therefore, the paradoxical character of lying?

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¹ Cf. Haynes (1979).

² Term used in France to designate doctors specialised in the treatment of alcoholism.

³ If, for Alcoholics Anonymous, abstinence is equivalent to the decision not to consume a product to which one is naturally allergic, in order to avoid the serious consequences of an incurable illness, for *Vie libre*, on the other hand, it amounts to the will to no longer have any contact with the cause of the illness as soon as the individual is weakened. But, the necessity of abstinence, asserted by the group, does not mean that it is impossible to recover from alcoholism. The difference is that it is essentially through fighting (resisting social pressures, publicity, alienation) that the illness can be avoided. Abstinence is the first militant act of the drinker who wishes to recover.

⁴ It is remarkable that this type of information was only available to me after I had been visiting the people for a long time, in their own homes, and that it was often hidden from me too, during my enquiries in the hospital environment among day patients or during consultations, where I embodied in spite of myself the medical institution.

⁵ If some fear being blamed by the doctor to whom they might say that they had followed the interdictions linked to Ramadan, others however willingly use Ramadan as a legitimate reason for not following prescriptions, but do not mention any other reasons.

⁶ Even if he adds further on that “to all other people, lying is forbidden, and we will say that the individual who lies to the chiefs commits a fault of the same nature but bigger, than the patient who does not tell the truth to the doctor. (...) (p. 140)”.

⁷ It is striking to see that in numerous social situations, secrecy is valorised whereas lying is devalued: moreover, one promises to keep a secret, but one does not promise to lie.

⁸ In the cases of double blind therapeutic trials, the use of a placebo does not pose the same problems. If the placebo effect is a lie and confronts the doctor with an ethical question, it is undertaken with the agreement of the patients and is therefore not an imposture but a test.

⁹ An attitude observed, here again, particularly among Catholic doctors who inscribe more in a social doctor / patient relationship on the lines of a power relationship.

¹⁰ Cf. Tambiah (1990 : 147).

¹¹ The simple fact that lying is more often practised by patients of Catholic and Muslim origin, as we have seen earlier, is not fortuitous, in the measure that patients develop a different rapport towards authority in general (of which medical authority is an avatar), according to their cultural religious origin (Fainzang 2001a).

¹² Ethnological literature reveals that, in some societies, it is dangerous to say ‘no’ to someone who is in a superior position. Barnes 1994 underlines that, in some cultures, this constraint exists even among equals, and that there is a repugnance towards being in open conflict (Dentan 1970, quoted by Barnes).

¹³ On the notion of paradox, see Fainzang (2001b).

¹⁴ In a world (the medical world) where it could be expected that things are governed by reason.