Sylvie FAINZANG

Anthropologue, spécialisée dans le domaine de la santé.
Directeur de recherche à l'Inserm et membre du CERMES
Centre de Recherche Médecine, Sciences, Santé et Société)

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“When doctors and patients
lie to each other. Lying and power
within the doctor – patient
relationship”

Un document produit en version numérique par Jean-Marie Tremblay, bénévole,
professeur de sociologie au Cégep de Chicoutimi

Courriel: jean-marie_tremblay@uqac.ca

Site web pédagogique : <http://www.uqac.ca/jmt-sociologue/>

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Courriel : sylvie.fainzang@orange.fr

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Anthropologue, spécialisée dans le domaine de la santé.
Directeur de recherche à l’Inserm et membre du CERMES
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INTRODUCTION

[To Summary](#)

Advocated by Hippocrates when it is made by medical doctors, but deplored by him when it is accomplished by patients ¹, lying is a common practice within the doctor-patient relationship. 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 various 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. We will show what links and what distinguishes the notions of secret, concealment and lying, and we will see that these differences are often more differences of degree than of nature. It will be demonstrated, on the one hand, that

¹ Cf. Haynes (1979).

lying is a constituent part of the doctor – patient relationship, both a means and a sign of the power that each party derives from this relationship, and that, in this respect, lying is in direct relation to the social role that each one has to perform; 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.

DOCTORS’ LIES

[To Summary](#)

The evocation of Hippocrates in the opening of this paper could pass for a simple rhetorical figure. It is not the case. Because the recommendations of Hippocrates, though inscribed in a medical, social and historical context very different from ours, are nonetheless still of this day, and relayed by numerous doctors. Thus, J. Hamburger says, speaking of the cases where the doctor is convinced that the illness of his patient is fatal and that he is unable to modify its course, that “we must lie, in all the cases, without any exception” (quoted by Abiven, 1996). Commenting on this statement (written by Hamburger in 1963 in a small booklet titled “Advices to the medical students in my department”), Abiven writes: “By asserting the necessity of lying in medical practice, J. Hamburger does nothing else than to make use of his authority to justify the most common practices of his time”. Yet, this time is far from over. Abiven writes on this issue, that “it is when the ill person is struck down by a mortal disease that the medical lying is most often practised”.

Doctors themselves 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 telling the truth. R. Brauman, president of *Médecins sans frontières*, says: “I don’t lie, but sometimes keep back the truth through necessity”, while some oth-

ers 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 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’ ².

However, the question of doctors’ lies does not come down to the revelation of diagnosis. We have seen this in the previous example, but it can be seen in many other cases. While some doctors only give information to patients with the view to enabling the latter to make a decision which conforms to the doctor’s 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 others to retain information 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 discourage patients to read information leaflets (“you read too much!” they tell them), because it might dissuade them from taking the prescribed treatment. Other doctors go so far as to contest information contained in pharmaceutical leaflets, so that the patients comply. A doctor justified his lying in this way: “It is true that there are cases where these side effects occur, but I prefer to tell her it never happens, or else, she will not take this treatment. Don’t tell her that the risk exists, she must believe that there is no risk!”.

In this case, telling a lie cannot be ascribed to ignorance of the truth, neither shall we confuse the notion of truthfulness with that of reality. With regards to this, we will distinguish, along with Simmel (1964), lies 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 at whom it is aimed believe it. In the same way, Bensaïd (1983) shows that in the expression “to tell the truth”, it is less the

² 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.

(medical) truth than the fact of telling it which matters. The stress is on the truth said, of which the antithesis is not error but lies (quoted by Geets, 1993).

The lies told in this instance by members of the medical profession 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 medical doctors, to speak the truth can result in behaviour or a situation which might be prejudicial to the patient's cure. Lying is strategic within the framework of therapeutic activity. It expresses a position of power, even if it aims to be beneficial and positive 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.

PATIENTS' LIES

[To Summary](#)

In their turn, patients do not refrain from lying to their doctors, in various pathological contexts. During research into the social behaviour of patients from diverse cultural origin with regards to medical prescription, medicines and doctors (Fainzang 2001a), I noticed that a certain number of patients lied to their doctor during consultation. This telling of lies takes several forms: For example, the patient claims to have taken his medication, when this is not the case. In fact, when treatment does not suit the patient, he seldom discusses this with the doctor but decides in secret not to follow it, even going so far as to confirm the opposite, 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 involves auto-medication or in instances of homeopathic treatment, when the patient knows or supposes that his doctor is not convinced of the efficacy 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, or even alternative therapies 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 relationship that a lie has with secrecy, whilst also 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 (not divulging the truth or telling the falsehood) to escape from its wrath, avoid conflict, criticism, or blame.³ 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 as 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 indistinctly apply the same behaviour model to all the subjects of one social group, any more 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 their use of an alternative remedy, while nevertheless pretending 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

³ 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.

more common in working class 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 turning 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 stopped doing so ⁴. In fact, submission seems to be an important value in Muslims: the name itself (Muslim, *mousslim* in Arabic, means 'submissive', from the word Islam which meaning is submission). This behaviour in Muslims is linked to a certain lack of distinction 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, a 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

⁴ 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.

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!".

Telling a lie is therefore a means of dissimulation resulting from 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, though lying is achieved for very different reasons by medical doctors and by patients, their lies have in common a certain number of elements, which could be deemed structural, with regards to the links between lying and the exercise 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

[To Summary](#)

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. 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 of South America, that the exercise of power is in fact a 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 (1977) adds that the exercise 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 exercise of power and holding back knowledge: the doctor jealously keeps a secret vis-à-vis a person who is dependent on him. Examining the issue of knowledge and 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 exercise 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 a mechanism of holding back information connected to the exercise of power, in the medical field, secrecy is generally seen as silence by the doctor in relation to what concerns the patient, for the benefit of the latter. A certain number of authors underline the necessity to maintain 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 to withhold information, to keep 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 their situation or not. 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 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 a case that Higgins reported (1986) when a doctor to whom a colleague asked if he had revealed the nature of a patient's illness to him 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 nevertheless maintain reciprocal links of inclusion because secrecy can imply lying and lying entails secrecy, in other words it implies keeping the truth secret. In this respect, lying must be re-

garded 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 of 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 that doctors' lies are morally justified. 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 city ⁵.

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

⁵ 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)".

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".

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 mask 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 lies assume in the therapeutic relationship ⁶. In fact, secrecy and lying are connected in different ways according to whether we consider 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

[To Summary](#)

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 that unites them. On the side of the doctors, power within the doctor-patient relationship is expressed through the appropriation of the patient's body. Numerous doctors claim the privilege of knowledge concerning the patient's body and tend not to disclose information that might enable the patient to make his own choices concerning his being. It is striking to note that this appropriation is more achieved by Catholic than by Protestant doctors (Fainzang 2001a), an observation which partly tallies with that of Gordon (1991). Deborah Gordon speaks about the cultural basis of this practice, which consists of not stating and not recognising a

⁶ 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.

diagnosis of cancer. Contrary to practice in North America, she notes that in Italy there exists a cultural consensus surrounding the decision not to tell the truth regarding this subject: it is current practice in Italy not to inform cancer patients of their diagnosis.

However, as we have seen, the doctors' lying does not come down only to revelation of diagnosis, since some doctors go as far as saying to their patients that what is written on the information leaflets regarding the possible side effects of medication is false, in order to lead their patients to comply with their prescriptions. Whether they imply the absence of a serious illness like a cancer 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 it ⁷.

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 exercise of power but the expression of resistance to the power of others. The fact that both can lie, whether the dominant or the dominated, the weak or 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 with telling a falsehood or keeping back the truth, lying can as much express the exercise 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

⁷ Cf. Tambiah (1990 : 147).

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 simultaneously reinforce 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 resistance ⁸.

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 Malaysia ⁹, 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, as was 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 regard 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 of saying that it is not admitted or perceived in the

⁸ 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).

⁹ 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).

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. Performing lying and the form that it takes are at the same time the expression and the conditions of reinforcing the inequality of the doctor/patient relationship: in this relation, where power is given to the doctor and denied to the patient, the lying of the first expresses his way of exercising it, whereas the lying of the second, expresses his way of taking it.

LYING AND PARADOX

[To Summary](#)

We will come back here to the question of rationalisation of lying in order to examine to what extent this notion can distinguish the lying of doctors from the lying of patients. 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 irrational when employed by patients: it harms treatment and cure because it hides information that is necessary to carry out his job, from the doctor. Yet lying is no more rational on one side than the other. Not only because patients also have their 'reasons' for lying, but also because lying is, in both cases, governed by cultural and not only utilitarian, functional or rational reasons and that the first ones are susceptible to take over from the latter.

Among the various kinds of rationalisation which underlie lying by doctors, 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 lies by doctors and patients is that the rationalisation of the first is accompanied by its moral justification (the will to not cause harm, to help towards the cure, etc. – cf. Henderson [1970] on the “disastrous consequences of the truth” –, indeed to make the good ¹⁰, while if patients also rationalise their lies, to either not upset the doctor if he learns the truth, or not to 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 their confidence or admit their faults, as sometimes happens this experience takes on the appearance of a confession.

As a counterpoint to the rationalisation of the lies told by medical health practitioners (and that have a justification value), D. Sicard (President of the National Ethics Advisory Committee in France) 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). B. Hoerni (1999), in turn, lays down the necessity of informing the patient as the respect due to a person’s autonomy.

Rationalisation of lying by doctors is largely achieved in medical and common sense discourse. It is brought to light through certain official ethical and deontological texts, which legitimise its use. In this regard, 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). Contrastingly, 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”.

¹⁰ Cf. “the right to lie out of humaneness” of Benjamin Constant, quoted by Morana [2003].

Yet, as rational as the practice of lying on the part of doctors can be, it is nevertheless paradoxical ¹¹ with regards to the objectives claimed 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 means to oblige the patient to comply with medical prescriptions, does not accord with those professions of faith in favour of the patients’ access to education, information or enlightenment.

Likewise, patients’ lies are paradoxical: not only do they go against the doctors’ therapeutic objectives from which they expect efficiency and into whose hands they place their bodies and fate — by behaving in a manner contradictory to that of willingly allowing the doctor to carry out his role efficiently —, but they simultaneously convey and reinforce their subordinate position in the face of medical authority.

CONCLUSION

[To Summary](#)

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. 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. Thus, in lying, the patient performs the role which is allotted to him: that of the one who must not contest the decision of the other. Since Parsons, much has been written about the social role of the patient, but the decisive role of lying has not been integrated into it. Yet his social role implies the use of lies because of the submissiveness he has to show. The doctor, as for him, performs the role of the one who decides for the patient and who lies, if necessary, to this end, that is, in order to

¹¹ On the notion of paradox, see Fainzang (2001b).

make the patient conform to his decision. Through lying, each one plays the role which is attributed to him. The nature and the performance of lying are functions of the achieving of these roles.

However, if, as it has been noted, each one has a reason (even a rationalisation) at the basis of his lie, 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 the strictly therapeutic, which lead them to lie. Lying appears to be a product of the doctor-patient relationship, which evades the only therapeutic reason ¹² because it is underlied by cultural and social logics.

This leads to questioning the idea that actors always behave in a conscious and reflective manner. Of course, here lying is part of a deliberate process, integrated into a strategy for which the subject can develop his reasons, or rationalization. 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 their grounds are? Do they see the trace of the exercise 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? Finally, do they see that this relationship is socially and culturally constructed, so much so that the use of lying is a social practice directly engendered by this construction, and that is often prevails over its medical functionality? In other words, do they see that the resort to lying and its performance have an efficiency which is much more social than therapeutical?

¹² In a world (the medical world) where it could be expected that things are governed by reason.

REFERENCES

[To Summary](#)

Abiven M., 1996, "Mentir pour bien faire? Ou le mensonge en médecine, *Etudes psychothérapiques*, 13 : 39-50.

Arendt H., 1972, *Du mensonge à la violence, Essais de politique contemporaine*, Paris, Calmann-Lévy.

Armstrong, D., 1987, Silence and truth in death and dying. *Social Science and Medicine*, 24: 651-657.

Augé M. ed., 1974, *La construction du monde*. Religions, représentations, idéologies, Paris, Maspéro, Dossiers africains.

Barnes, J. 1994. *A pack of lies: Towards a sociology of lying*. Cambridge: Cambridge University Press.

Bensaïd N., 1983, « Dire la mort », *Le genre humain*, 7-8.

Bok, S. 1979. *Lying: Moral choice in public and private life*. New York: Vintage books.

Carricaburu D. & Pierret J., 1995, « From biographical disruption to biographical reinforcement: the case of HIV-positive men », *Sociology of Health & Illness*, 17, 1 : 65-88.

Clastres P., 1974, *La société contre l'Etat*, Paris, Editions de Minuit.

Coll., 1996, « Le secret », *La Revue Agora*, n°37.

Constant B., 1796, « Tout le monde n'a pas droit à la vérité » (texte tiré de : *Des réactions politiques*, chap. VIII: "Des principes »), in : Morana 2003.

Dentan R.K., 1970, « Living and working with the Semai », in : Spindler G.D., ed. : *Being an anthropologist : fieldwork in eleven cultures*, New York : Holt, Rinehart & Winston : 85-112.

Dozon et Vidal eds, 1993, *Les sciences sociales face au sida*, Paris, Ed. de l'Orstom.

Duval M., 1985, *Un totalitarisme sans Etat. Essai d'anthropologie politique à partir d'un village burkinabé*. Paris, L'Harmattan.

Ekman P., 1985, *Telling lies. Clues to Deceit in the Marketplace, Politics and Marriage*, W. W. Norton & Cie, New York/London.

Fainzang S., 2001a, *Médicaments et Société. Le patient, le médecin et l'ordonnance*, Paris Presses universitaires de France.

Fainzang S., 2001b, « [Cohérence, raison et paradoxe. L'anthropologie de la maladie aux prises avec la question de la rationalité](http://alor.univ-montp3.fr/cerce/revue.htm) », *Ethnologies Comparées*, n°3 ("Santé et maladie: questions contemporaines"), [<http://alor.univ-montp3.fr/cerce/revue.htm>].

Favereau E., 1994, *Le silence des médecins*, Paris, Calmann-Lévy.

Foucault M., 1980, *Power/knowledge, Selected Interviews and other writings, 1972-1977*, Colin Gordon ed., New York : Pantheon Books.

Geets C., 1993, « Vérité et mensonge dans la relation au malade », *Le Supplément*, 184 : 56-77.

Giddens A., 1987, *La constitution de la société*. Paris : PUF.

Gordon D.R., 1991, Culture, Cancer & Communication in Italy, in: *Anthropologies of Medicine*, B. Pfleiderer & G. Bibeau eds., Curare, 7 : 137-156.

Gruénais M.E., 1993, Dire ou ne pas dire. Enjeux de l'annonce de la séropositivité à Brazzaville (Congo), in: J.P. Dozon et L. Vidal (eds), *Les sciences sociales face au sida. Cas africains autour de l'exemple ivoirien*, Centre Orstom de Petit-Bassam, GIDIS-CI/Orstom, 207-220.

Hacking, 1982, « Language, Truth and Reason », in Hollis & Lukes eds., *Rationality and Relativism*, Oxford, Basil Blackwell : 48-66.

Henderson L. J., 1970 (1935), « Physician and patient as a social system », in : *On the social system : selected writings*, Chicago, University of Chicago Press : 202-213.

Higgins R.W., 1986, « Aspects philosophiques de la vérité », *Jalmav*, n°7 (« La vérité »): 5-10.

Hoerni B., 1999, « Communiquer l'information médicale. De nouvelles responsabilités partagées »,

in : Hirsch E. ed., *Espace éthique. La relation médecin-malade face aux exigences de l'information*, Dossiers de l'APHP, Paris, Doin editeurs/APHP.

Jamin J., 1977, *Les lois du silence. Essai sur la fonction sociale du secret*, Paris, Maspéro, Dossiers africains.

Jamous R., 1993, « Mensonge, violence et silence dans le monde méditerranéen », *Terrain*, 21 : 97-110.

Katz J., 1984, *Silent World of Doctor and Patient*, New York, Free Press.

Maheu E., 1996, « Secret et transparence : un enjeu démocratique », *La Revue Agora*, n°37 : 3-8.

Morana C. (présenté par -), 2003, *Le droit de mentir. B. Constant, E. Kant*, 2003, Fayard.

Perez, Z. 1996. The historical significance of lying and dissimulation. *Social Research* 63:863-912.

Petit, *Secret et formes sociales*, PUF, 1998, coll. « Sociologie d'aujourd'hui ».

Platon, 1966, *La République*, Paris, G. Flammarion.

Radstake M., 2000, *Secrecy and Ambiguity. Home care for people living with HIV/AIDS in Ghana*, African Studies Centre, Research Report 59, Leiden.

René L. 1996, Le secret médical : vertu bourgeoise ou valeur humaniste, *La Revue Agora*, n°37 : 109-114.

Roqueplo P., 1974, *Le partage du savoir. Science, culture, vulgarisation*, Paris, Le Seuil.

Shibles W., 1985, *Lying : A Critical Analysis*, Whitewater, Wisconsin, The Language Press.

Sicard D., 2000, « Le médecin et ses malades – le malade et ses médecins », in : Yves Michaud ed., *Qu'est-ce que l'humain ?* vol. 2, *Université de tous les savoirs*, Paris, Odile Jacob.

Simmel G., 1964, « The Secret and the Secret Society », in : *The sociology of Georg Simmel*, Glencoe/London, The Free Press.

Tambiah S.J., 1990, *Magic, Science, Religion and the Scope of Rationality*. Cambridge / New York : Cambridge University Press.

Wise, D. 1973. *The politics of lying: Government deception, secrecy and power*.

Zempléni A., « La chaîne du secret », in : « Du secret », *Nouvelle revue de psychanalyse*, n°14, 1976: 313-324.

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