THE TRUTH

"It takes two to speak the truth, one to speak and another to hear."
Henry David Thoreau

On occasions my friend Henry and I meet for lunch at the Sagewood Café and have deep discussions on nefarious subjects over toasted sandwiches. Today was a debate on whether one should rather tell a lie that softens or the truth that hurts. We also turned it the other way around with the proposition that it was better to be hurt by the truth than comforted by a lie. This arose from a patient I was looking after in an old age home who suffers from pre-dementia. I get asked the same question by this patient, "will my husband be coming today?" Her husband has been dead for several years.

In this manner another perennial ethical dilemma arises when one has to inform a patient that they have cancer or a life threatening disease. Decisions of this kind are influenced by the patient's character and beliefs as well as those of family members. This is all weighed up with the stages of the disease, the prognosis and the context within which the patient lives.

One of the benefits of general practice is that giving information is not necessarily a now-or-never affair but is often a considered process over the progression of time. This process often depends on choosing the right time to give the information; what the French call *le moment juste*. It is an intuitive moment which gives one an opening to discuss a sensitive subject.

In recent years the right to know has become paramount in bioethical circles unless there are exceptional circumstances involving cultural, religious or personal beliefs. Dilemmas, though, arise when a competent patient requests not to know a diagnosis or prognosis.

There is also the "white lie" which is the grey area (if you will pardon the chromatic metaphors) between the absolute pure truth and the deliberate dishonest lie. The white lie involves the subtle variations between the absolute truth (which is a disputed phenomenon in philosophy) and the black mendacious lie. Between the two are the relativistic approaches of partial disclosure as well as the concept of therapeutic privilege.

Therapeutic privilege allows physicians to withhold information when they think a patient may be unable to cope with the information or may be harmed by the information. In official language this goes "except in circumstances where there is substantial evidence that such disclosure would be contrary to his/her best interests." (National Health Act 2003,9, Section 6 (1)(a)).

One of the main reasons for not informing the patient of the full truth may be the doctor's concern that the patient may refuse a treatment that is in their best interests. The other common reason is that the news may cause extreme anxiety especially in those who are already anxious or already suffer from a general anxiety or psychiatric disorder.

Lying can be defined as the direct communication of a statement one knows to be false. There can also be several gradations to these communications. Deception, for instance, is actively and intentionally causing a patient to adopt a false belief and is done with deliberate intent. This raises the complex philosophical dilemma between always telling the truth exactly as it is (the Kantian deontological approach) and giving false statements or partial disclosure in order to procure a good outcome (the consequentialist/utilitarian approach). Another slight variation on this theme is "concealment" when one intentionally avoids communicating all the relevant information to a patient. Almost unintentionally, we may use "misleading" euphemisms and what Winston Churchill called "terminological inexactitudes". Even silences and non-verbal responses may be used to create either an impression of affirmation or disapproval.

In some cultures there is a belief that statements may generate a self-fulfilling prophecy such as informing the patient of side effects, which will then make them happen, almost like letting the genie out of the bottle. Into this complex mixture is the choice of words one uses and the different forms of language manipulation that influences the patient. The tone of voice, timing, inflection and emphasis or lack of emphasis all play a part in how information is conveyed and interpreted.

It is never completely possible to eliminate our agendas to help the patient and therefore we may convey our information in many one-sided ways. "If falsehood, like truth, had only one face," said Michelle De Montaigne in the 16th century, "we would be in better shape. For we would take as certain the opposite of what the liar said. But the reverse of truth has a hundred thousand shapes and a limitless field".

During the long years of medical training, we are imprinted with ways to seek and tell the finite truth or as nearly as we can get to it. In our mechanistic thought processes, we work in a linear way towards an objective (diagnosis) and a goal (outcome). This gives us security of purpose in a clinical and technological discipline. The apotheosis of this training is the concept of evidence-based medicine. We rationalise within systems and like to order our thoughts deterministically in order to achieve cures and outcomes, which we believe are medically best for the patients. This is the doctor's truth but this may not be the truth for the patient. Vladimir Lenin putatively said "Do not ask, is it true? Ask, true for whom?"

"True for whom" is one of the enigmas in medical practice when giving information to patients and when helping patients make decisions.

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