duty to act in order to save the life or preserve the health of the patient; and that in the honest execution of that duty he should not be exposed to legal liability' (Chisholm, C J in *Marshall* v. *Curry*, 1933, 3 D.L.R. 260).

And there I must stop. But not in the arid terms of a lawyer. Let me instead leave you with the memorable words of an American physician (Henderson 1935). Writing on the issue of truth, he said:

'Far older than the precept, "the truth, the whole truth, and nothing but the truth", is another that originates within our profession, that has always been the guide of the best physicians, and, if I may venture a prophecy, will always remain so. So far as possible, "do no harm". You can do harm by the process that is quaintly called telling the truth. You can do harm by lying . . . It will arise also from what you say and what you fail to say. But try to do as little harm as possible, not only in treatment with drugs, or with the knife, but also in treatment with words, with the expression of your sentiments and emotions. Try at all times to act upon the patient so as to modify his sentiments to his own advantage, and remember that, to this end, nothing is more effective than arousing in him the belief that you are concerned whole-heartedly and exclusively for *his* welfare.'

If a doctor fits his actions to these words, his patient can have no cause for complaint and the doctor need fear neither the law nor his own conscience, whatever be the truth told or withheld.

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I would like to speak about two recent experiences which I regard as perfectly normal incidents, not the sort of borderline cases for which exceptions obviously have to be made. They have brought this issue home to me in a way that I find disturbing.

The first relates to two of the most devoted, articulate and sensitive people I know. The husband has recently died of cancer and I have been in fairly close contact with the wife. She was strongly and persistently urged not to tell her husband what was wrong, or that he had only a few months to live. I found this case very disturbing because even when one telephoned one never knew what one could say until she had gone to another room, and it seemed to me that for the whole of the last six months that couple was condemned to living a lie, that they were simply unable to communicate at any deep level. This resulted from a sort of collusion between the doctor, the wife and the patient which I found extraordinarily difficult to accept. I know that she did, too, but she was absolutely convinced that she must follow what the doctor said and realized that this was being done with the best possible motive, for the sake of the patient. It is when one finds oneself caught up in an agonizing choice like this that one begins to ask oneself who is protecting whom, who is deceiving whom?

Once you have started on such a course of action it is even more difficult to back-track. Can it really be right, apart from really exceptional circumstances? Certainly my wife and I both feel that if either of us found ourselves in this position we just could not go along with it. It does deprive the patient of the right to be treated as a whole moral human being and, above all, of a right to a prepared death, which is not simply a question of setting one's affairs in order. It is a question of a moral and spiritual relationship, which we all have to face, and which none of us can slough off on to anyone else.

The second instance was when I was taken the other day by a parish priest to see one of his most dedicated and intelligent laymen, also a very convinced Christian. He was a PhD research chemist working in industry and his wife was a nurse. He was recovering from a brain operation which had revealed that he had an inoperable growth. He was firmly convinced that it was simply a cyst and that he was getting better. One had to admire the marvellous courage of both partners but again what worried me was that it was quite palpably based on a pretence. Again I took away the sense almost of outrage and indecency that the parish priest, a friend of his at Cambridge and myself, who had seen him once, all knew and he did not. This seems morally an intolerable situation. After all, it is his truth, and in a sense we have no right to have this truth and to talk about it among ourselves behind his back. Above all, if this deception was discovered, and it seems almost impossible that in the long run it would not be, then all trust is irrevocably destroyed. It may be well meant but it does seem, again, that it is preventing a person from being a full, moral, responsible human being.

I feel that, whatever the legal situation, morally the doctor owes the patient the truth because basically it is his truth. Having said that, one has

to make all sorts of recognitions and qualifications. As T S Eliot said: 'Human kind cannot bear very much reality.' Some can bear very little reality. It is quite clear that deep down a great many people do not want to know and indeed there appears, as you all know, to be an astonishing capacity for imperception of the truth about ourselves. I recall another friend of mine, an elderly man slowly dying of cancer, whose son-in-law said: 'He appears to have forgotten that he has cancer.' That is part of the defence that we all have in situations like this, in coming to terms with it. The last thing in the world one is advocating is that the truth should be forced upon people. We must accept their freedom to accept and to refuse the truth.

I am still left with where the onus lies. It is not a simple issue. The real questions are: How do you tell the truth? When do you tell the truth? By whom is it to be told? To whom is it to be told? Anything that is hurtful or casual or brutal is clearly excluded. This makes the situation from my experience particularly difficult in hospitals because this is essentially a function of personal relationships and so many of the relationships in hospitals are inevitably of a short-term nature and are remote or casual. I remember very well being at the receiving end of such information once when I was casually told by the house surgeon that my wife had a fifty-fifty chance of recovery. This I found to be a shattering experience. It was no doubt probably absolutely true and I would not have been shielded from it but on the other hand the way in which it was told, without any intention, I am sure, on the part of the person concerned, was pretty devastating.

This does involve an honesty both about what we know – and we have to qualify any of the statements we make by the ignorance in which we may make them – and also an honesty about what we feel and a sensitivity to the relationship. Having said this, I feel I must end by putting the onus squarely on the side of telling the truth rather than withholding it.

All of us as patients have a double attitude towards doctors. Our attitude is one of enormous respect and trust, but also of niggling suspicion that they are engaged in some sort of conspiracy to withhold the truth or at any rate to treat one as a person who cannot be expected to understand. I remember so well as a child being infuriated that I was never allowed to look at the thermometer to see what my temperature was. I never discovered what good it did; it merely seemed to make me suspicious of the doctors or nurses who did not want me to know. I used to sneak to the bottom of the bed and look at my temperature chart when no one was looking.

What I would look for more than anything else in my doctor would be a preparedness to be absolutely honest and truthful with me. As soon as I got the impression that he was being evasive or equivocating or withholding something, even if it was, as he thought, for my good, my suspicions would be aroused and I suspect that in that situation a healing relationship would become progressively more difficult. A priest who has been trained for this situation knows, perhaps more than a doctor, that *how* one tells a patient the truth about himself makes tremendous demands upon both. It is a great burden that is laid upon us but one which I feel we must nevertheless accept.

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I do not question the patient's right to know or his right not to know, but I do insist upon my right – no, my responsibility – to ensure that knowledge of dreadful import is communicated in a manner which will do as little harm as possible to my patient and his family.

The important question to my way of thinking is not: 'Should the doctor tell?', but: '*How* should the doctor tell and when?' Because of our human capacity to anticipate events we often have the opportunity to prepare ourselves for what is to come. This means that we can often mitigate the shock of a traumatic occurrence by gradually coming to terms with it in advance.

In a recent study of 68 young American widows and widowers who were interviewed at intervals after bereavement, there were 24 who had had little advance warning that their husbands or wives were going to die (Parkes *et al.* 1973). Their reaction to bereavement was much more severe and prolonged than those who had had adequate warning. Even two, three or four years later these men and women were significantly more depressed, more anxious, self-reproachful and coping less well with financial and other responsibilities than those who had had at least two weeks warning that death was likely to occur and at least three days' warning that it was imminent. It seems, therefore, that advance warning of an approaching death is important to the mental health of survivors.

The American psychologist Irving Janis (1958) has coined the term 'worry work' for the anticipatory worrying which we do in advance of critical life events such as surgical operations. He believes that worrying is an important part of the process of preparing ourselves for such events and it may be that a bereavement is less easy to tolerate if we have not had the opportunity to worry about it