TRUTH AND THE PHYSICIAN*

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"Truth does not do so much good in this world as the semblance of it does harm."
—LA ROCHEFOUCAULD: *Maxim 64*

AMONG the reminiscences of his Alsatian boyhood my father related the story of the local functionary who was berated for the crude and blunt manner in which he went from house to house announcing to wives and mothers news of battle casualties befalling men from the village. Mindful of the injunction to be more tactful and to soften the impact of his doleful messages, on the next occasion he rapped gently on the door, and, when it opened, inquired, "Is the widow Schmidt at home?"

Now insofar as this essay is concerned with the subject of truth it is only proper to add that when I told this story to a colleague he already knew it and asserted that it concerned a woman named Braun who lived in a small town in Austria. By this time it would not surprise me to learn that the episode is a well-known vignette in the folklore of Tennessee where it is attributed to a woman named Smith or Brown whose husband was killed at the battle of Shiloh. Ultimately indeed it may turn out that all three versions are plagiarized accounts of an actual happening during the Trojan War.

Apocryphal or not, the story illustrates a few of the vexatious aspects of the problem of conveying unpalatable news, notably the difficulty of doing so in a manner that causes minimal pain, and also the realization that not everyone is capable of doing it; and in the field of medicine the imparting of the grim facts of diagnosis and prognosis is a constantly recurrent issue. Nor does it seem likely that for all our learning we doctors are particularly endowed with superior

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talents and techniques for coping with these problems. On the contrary, for reasons to be given later, there is cause to believe that in not a few instances elements in his own psychological make-up may make the physician singularly ill-equipped to be the bearer of bad tidings. It should be observed, moreover, that until comparatively recent times, the subject of communication between physician and patient has received relatively little attention both in the medical curriculum and in the medical literature.

Within the past decade or so, coincidentally with an expanded recognition of the significance of emotional factors in all medical practice, an impressive number of books and articles by physicians, paramedical practitioners, and others have been published. These contributions attest both the growing awareness of the importance of the subject and an apparent willingness to face it. An especially noteworthy example of this trend was provided by a three-day conference in February 1967 sponsored by The New York Academy of Sciences on *The Care of Patients with Fatal Illness.* Needless to say the problem of communicating with such patients and their families appeared as a recurrent theme in most of the papers presented. Both at this conference and in the literature particular emphasis has been focused on the patient with cancer, which is hardly surprising in light of its frequency and of the extraordinary emotional reactions that it unleashes not only in the patient and in his kinsmen but in the physician himself. At the same time it should be noted that the accent on the cancer patient or the dying patient may foster the impression that in less grave conditions this dialogue between patient and physician hardly warrants much concern or discussion. Such a view is unfounded, however, and could be espoused only by someone who has had the good fortune to escape the experience of being ill and hospitalized. Those less fortunate will readily recall the emotional stresses that are induced by hospitalization, even when the condition requiring it is relatively banal. A striking example of this may sometimes be seen when the patient who is hospitalized for, let us say, repair of an inguinal hernia, happens to be a physician. All the usual anxieties that confront a prospective surgical subject tend to become greatly amplified and garnished with a generous sprinkling of hypochondriasis in the physician-turned-patient. Wavering unsteadily between these two roles, he conjures up visions of all the complications of anesthesia, of wound dehiscence or infection,

of embolism, cardiac arrest, and whatnot that he has ever heard or read about. To him, lying between hospital sheets, clad in impersonal hospital clothes, divested of his watch and of the keys to his automobile, the hospital suddenly takes on a different appearance from the place he may have known in a professional capacity. Even his colleagues—the anesthetist who will put him to sleep or cause a temporary motor and sensory paralysis of the lower half of his body, and the surgeon who will incise it—look different. The physician would like to have a little talk with them, a very professional talk to be sure, although in his heart he may know that the talk will also be different. And if they are in tune with the situation, they too know that it will be different, that beneath the restrained tones of sober and factual conversation is the thumping anxiety of a man who seeks words of reassurance. With some embarrassment he may introduce his anxieties with the phrase, "I suppose this is going to seem a little silly, but—" and from this point on he may sound like any other individual confronted with the ordeal of surgical experience.*

Indeed it would appear that under these circumstances, to say nothing of more ominous ones, most people, regardless of their experience, knowledge, maturity, or sophistication, are assailed by more or less similar psychologic pressures, from which they seek relief not through pharmacologic sedation, but through the more calming influence of the spoken word.

Seen in this light the question of what to tell the patient about his illness is but one facet of the practice of medicine as an art, a particular example of that spoken and mute dialogue between patient and physician which has always been and will always be an indispensible ingredient of the therapeutic process. How to carry on this dialogue, what to say and when to say it, and what not to say, are questions not unlike those posed by an awkward suitor; like him, those not naturally versed in this art may find themselves discomfited and needful of the prompt-

*It should be observed, however, that while the emotional conflicts of the sick doctor may contribute to the ambiguity of his position, that ambiguity may be abetted by the treating physician, who in turn may experience difficulty in assigning to his ailing colleague the unequivocal status of patient. Indeed the latter may be more or less tacitly invited to share the responsibility in the diagnosis and care of his own illness to a degree that in some instances he is virtually a consultant on his own case.

A similar lack of a clear-cut definition of role is not uncommon when members of a doctor's family are ill. Here a further muddying of the waters may be caused by the time-honored practice of extending a so-called courtesy—i.e., free care—to physicians and their families, a custom which, however well-intentioned, may place its presumed beneficiaries in moral straitjackets that discourage them from making rather ordinary demands on the treating physician, to say nothing of discharging him. It is not surprising that the care of physicians and their families occasionally evokes an atmosphere of rancor.

ings of some Cyrano who will whisper those words and phrases that ultimately will wing their way to soothe an anguished heart.

The difficulties that beset the physician under these circumstances, however, cannot be ascribed simply to his mere lack of experience or innate eloquence. For, like the stammering suitor, the doctor seeking to communicate with his patient may have an emotional stake in his message, and when that message has ominous significance, he may find himself too troubled to use words wisely, too ridden with anxiety to be kind, and too depressed to convey hope. An understanding of such reactions requires a recognition of some of the several psychological motivations to have led some individuals to choose a medical career. There is evidence that at times that choice has been dictated by what might be viewed as counterphobic forces: for instance, recurring brushes with illness in childhood and a deep and abiding fear of death may cause some persons to embrace a medical career in the hope that it will confer upon them a magical immunity from a repetition of this dreaded eventuality; for them the letters M.D. constitute a talisman that bestows upon the wearer a sense of invulnerability and a pass of safe conduct across the perilous frontiers of life. There are others for whom the choice of a career dedicated to helping and healing appears to have arisen as a reaction formation against earlier impulses to wound and to destroy.* For still others among us the practice of medicine serves as the professional enactment of a long-standing rescue fantasy. It is readily apparent in these examples, which by no means exhaust the catalogue of motives leading to the choice of a medical career, that confrontation by the failure of one's efforts and by the need to announce it may loose a variety of inner psychological disturbances. Faced by the gravely ill or dying patient the "counterphobic" doctor may feel personally vulnerable again; the "reaction-formation" doctor, evil and guilty; and the "rescuer," worthless and impotent. For such as these, words cannot come readily in their discourse with the seriously or perilously ill; indeed they may curtail their communications and, what is no less meaningful to their patients, withdraw their physical presence. Thus the patient with inoperable cancer and his family may discover that the physician who at a more hopeful moment in the course of the illness had been both articulate and supportive, has become remote

*The notion that at heart some doctors are killers is a common theme in literature. It is said that when in a fit of despondency Napoleon Bonaparte declared he should have been a physician, Talleyrand commented: "Toujours assassin."

both in his speech and in his behavior. Nor is the patient uncomprehending of the significance of the change in his doctor's attitude. Observers have recorded the verbal expressions of patients who sensed the feelings of futility and depression in their physicians. Patients may offer excuses for their own reluctance to ask questions (a reluctance based partly upon their own disinclination to face a grim reality). One such patient said, "He looked so tired," another, "I don't want to upset him because he has tried so hard to help me," another, "I know he feels so bad already and is doing his best."[1]

To paraphrase a celebrated utterance one might suppose that these remarks were dictated by the maxim: "Ask not what your doctor can do for you; ask what you can do for your doctor."†

In the dilemma created both by a natural disinclination to be a bearer of bad news and by those other considerations already cited, many a physician is tempted to abandon personal judgment and authorship in his discourse with his patients, and to rely instead upon a set formula which he employs with dogged and indiscriminate consistency. In determining what to say to patients with cancer, for example, he may routinely apply standard policies in seeming disregard of the over-all clinical picture and of the personality or psychological make-up of the patient. In general two schools of thought prevail: those that always tell and those that never do; and each is amply supplied with statistical and anecdotal evidence proving the correctness of its policy. Yet even if the figures were accurate—and not infrequently they are obtained by a questionnaire, itself a rather opaque window to the human mind—all they demonstrate is that more rather than less of a given proportion of the cancer population profited by the policy employed. This gives small comfort, one might suppose, to the patients and their families that constitute the minority of the sample.

At times adherence to such a rigid formula is dressed up in the vestments of slick and facile morality. Thus a theologian has insisted that the physician has a moral obligation to tell the truth and that withholding it constitutes a deprivation of the patient's rights; therefore it is "theft, therefore unjust, therefore immoral."[4] "Can it be," he asks,

†This aspect of the doctor-patient relation has not received the attention it deserves. Moreover, aside from being a therapeutic success, there are other ways in which patients may support the doctor's psychological needs. The physician's self-esteem, no less than his economic well-being, may be nourished by an ever-growing roster of devoted patients, particularly when the latter include celebrities and other persons of prominence. How important this can be may be judged by the not too common indiscretions perpetrated by some physicians (and sometimes by their wives) in "leaking" confidential matters pertaining to their practice, notably the identity of their patients.

"that doctors who practice professional deception would, if the roles were reversed, want to be coddled or deceived?" To which, as many physicians can testify, the answer is distinctly "Yes." Indeed so adamant is this writer upon the right of the patient to know the facts of his illness that in the event he refuses to hear what the doctor is trying to say, the latter should "ask leave to withdraw from the case, urging that another physician be called in his place."*

(Once there were three boy scouts who were sent away from a campfire and told not to return until each had done his good turn for the day. In 20 minutes all three had returned, and curiously each one reported that he had helped a little old lady to cross a street. The scoutmaster's surprise was even greater when he learned that in each case it was the same little old lady, prompting him to inquire why it took the three of them to perform this one simple good deed. "Well, replied one of the boys, "you see she really didn't want to cross the street at all.")

In this casuistry, wherein so much attention is focused upon abstract principle and so little upon humanity, one is reminded of the no less specious arguments of those who assert that the thwarting of suicide and the involuntary hospitalization of the mentally deranged constitute violations of personal freedom and human right.* It is surely irregular for a fire engine to travel in the wrong direction on a one-way street, but if one is not averse to putting out fires and saving lives the traffic violation looms as a conspicuous irrelevancy. No less irrelevant is the obsessional concern with meticulous definitions of truth in an enterprise where kindness, charity, and the relief of human suffering are the essential verities. "The letter killeth," say the Scriptures, "but the spirit giveth life."

Nor should it be forgotten that in the healing arts the matter of truth is not always susceptible to easy definition. Consider for a moment the question of the hopeless diagnosis. It was not so long ago that such

*The same writer relaxes his position when it concerns psychiatric patients. Here he would sanction the withholding of knowledge "precisely because he may prevent the patient's recovery by revealing it." But in this too the writer is in error: in double error, it would seem; for, first, it is artificial and inexact to make a sharp distinction between psychiatric and nonpsychiatric patients—the seriously sick and the dying are not infrequently conspicuously emotionally disturbed; second, because it may at times be therapeutically advisable to acquaint the psychiatric patient with the facts of his illness.

**Proponents of these views have seemingly overlooked the unconscious elements in human behavior and thought. Paradoxical though it may seem, the would-be suicide may wish to live: what he seeks to destroy may be restricted to that part of the self that has become burdensome or hateful. By the same token, despite his manifest combativeness, a psychotic individual is often inwardly grateful for the restraints imposed upon his dangerous aggression. There can be no logical objection to designating such persons as "prisoners," as Thomas S. Szasz would have it, provided we apply the same term to individuals who are "incarcerated" in oxygen tents.

a designation was appropriate for subacute bacterial endocarditis, pneumococcal meningitis, pernicious anemia, and a number of other conditions which today are no longer incurable, while those diseases which today are deemed hopeless may cease to be so by tomorrow. Experience has also proved the unreliability of obdurate opinions concerning prognosis even in those conditions where all the clinical evidence and the known behavior of a given disease should leave no room for doubt. To paraphrase Georges Clemenceau: to insist that a patient is hopelessly ill may at times be worse than a crime; it may be a mistake.

There are other pitfalls, moreover, that complicate the problem of telling patients the truth about their illness. There is the naive notion, for example, that when the patient asserts that what he is seeking is the plain truth he means just that. But as more than one observer has noted this is sometimes the last thing the patient really wants. Such assertions may be voiced with particular emphasis by patients who happen to be physicians and who strive to display a professional or scientifically objective attitude toward their own condition. Yet to accept such asseverations at their face value may sometimes lead to tragic consequences.

A distinguished urological surgeon was hospitalized for hypernephroma; the diagnosis had been withheld from him. One day he summoned the interne into his room, and after appealing to the latter on the basis of we're-both-doctors-and-grown-up-men, succeeded in getting the unwary younger man to divulge the facts. Not long afterward, while the nurse was momentarily absent from the room, the patient opened a window and leaped to his death.

Another common error is the assumption that until someone has been formally told the truth he does not know it. Such self-deception is often present when parents feel moved to supply their pubertal children with the sexual facts of life. With much embarrassment and a good deal of backing and filling on the subjects of eggs, bees, and babies, sexual information is imparted to a child who often not only already knows it but is uncomfortable in hearing it from that particular source. There is indeed a general tendency to underestimate the perceptiveness of children not only about such matters but also where graver issues, notably illness and death, are concerned. As a consequence, attitudes of secrecy and overprotection designed to shield children from painful realities may result paradoxically in creating an atmosphere that is saturated with suspicion, distrust, perplexity, and intolerable anxiety. Caught

between trust in their own intuitive perceptions and the deceptions practiced by the adults about them, such children may suffer greatly from a lack of opportunity of coming to terms emotionally with some of the vicissitudes of existence that in the end are inescapable. A refreshing contrast to this approach has been presented in a paper entitled, "Who's Afraid of Death on a Leukemia Ward?"[6] Recognizing that most of the children afflicted with this disease had some knowledge of its seriousness, and that all were worried about it, the hospital staff abandoned the traditional custom of protection and secrecy; it provided instead an atmosphere in which the children could feel free to express their fears and their concerns and could openly acknowledge the fact of death when one of the group passed away. The result of this measure was immensely salutary.

Similar miscalculations of the accuracy of inner perceptions may be noted in dealing with adults. Thus in a study entitled: "Mongolism. When Should Parents Be Told?"[3] it was found that in nearly half the cases the mothers declared that they had realized before being told that something was seriously wrong with the child's development, a figure which obviously excludes the mothers who refused consciously to acknowledge their suspicions. On the basis of their findings the authors concluded that a full explanation given in the early months, coupled with regular support thereafter, appeared to facilitate the mother's acceptance of and adjustment to her child's handicap.

A pointless and sometimes deleterious withholding of truth is a common practice in dealing with elderly people. "Don't tell Mother" often seems to be an almost reflex maxim among some adults in the face of any misfortune, large or small. Here too, elaborate efforts at camouflage may backfire, for, sensing that he is being shielded from some ostensibly intolerable secret, not only is the elderly one deprived of the opportunity of reacting appropriately to it, but he is tacitly encouraged to conjure up in his imagination something that may be infinitely worse.

Still another misconception is the belief that if it is certain that the truth is known it is quite all right to discuss it. How mistaken such an assumption may be was illustrated by the violent rage which a recent widow continued to harbor toward a friend for having alluded to cancer in the presence of her late husband. Hearing her outburst one would have concluded that until the ominous word had been uttered her husband had been ignorant of the nature of his condition. The

facts, however, were quite different, as the unhappy woman knew, for it had been her husband who originally had told the friend what the diagnosis was.

The psychological devices that make such seeming inconsistencies of thought and knowledge possible are the mechanisms of repression and denial. It is indeed the remarkable capacity to bury or conceal more or less transparent truth that makes the problem of telling it so sticky and difficult a matter, and one that is so unsusceptible to simple rule-of-thumb formulas. For while in some instances the maintenance of denial may lead to severe emotional distress, in others it may serve as a merciful shield.

A physician with a reputation for considerable diagnostic acumen developed painless jaundice. When, not surprisingly, a laparotomy revealed a carcinoma of the head of the pancreas, the surgeon relocated the biliary outflow so that postoperatively the jaundice subsided. This seeming improvement was consistent with the surgeon's explanation to the patient that the operation had revealed hepatitis. Immensely relieved, the patient chided himself for not having anticipated the "correct" diagnosis. "What a fool I was!" he declared, obviously alluding to an earlier, albeit unspoken, fear of cancer.

Among less sophisticated persons the play of denial may assume a more primitive expression. Thus a woman who had ignored the growth of a breast cancer until it had produced spinal metastases and paraplegia, attributed the latter to "arthritis" and asked whether the breast would grow back again. The same mental mechanism allowed another woman to ignore dangerous rectal bleeding by ascribing it to menstruation, although she was well beyond the menopause.

In contrast to these examples is the case reported by Winkelstein and Blacher. A man who awaited the report of a biopsy from a cervical node asserted that if it showed cancer he would not want to live, and that if it did not he would not believe it.[8] Yet despite this seemingly unambigious willingness to deal with raw reality, when the chips were down, as will be described later, this man too was able to protect himself through the use of denial.

From the foregoing it should be self-evident that what is imparted to a patient about his illness should be planned with the same care and executed with the same skill that are demanded by any potentially therapeutic measure. Like the transfusion of blood, the dispensing of

certain information must be distinctly indicated; the amount given must be consonant with the needs of the recipient, and the type must be chosen with the view of avoiding untoward reactions. This means that only in selected instances is there any justification for telling a patient the precise figures of his blood pressure, and the question of revealing interesting but asymptomatic congenital anomalies should be considered in light of the possibility of evoking either hypochondriacal ruminations or narcissistic gratification. Under graver circumstances the choices confronting the physician rest upon more crucial psychological issues. In principle we should strive to make the patient sufficiently aware of the facts of his condition to facilitate his participation in the treatment without at the same time giving him cause to believe that such participation is futile. "The indispensable ingredient of this therapeutic approach," write Stehlin and Beach, "is free communication between [physician] and patient, in which the latter is sustained by hope within a framework of reality."[5] What this may mean in many instances is neither outright truth nor outright falsehood but a carefully modulated formulation that neither overtaxes human credulity nor invites despair. Thus a sophisticated woman might be expected to reject with complete disbelief the notion that she has had to undergo mastectomy for a benign cyst, but she may at the same time accept postoperative radiation as a prophylactic measure rather than as evidence of metastasis.

A doctor's wife was found to have ovarian carcinoma with widespread metastases. Although the surgeon was convinced she would not survive for more than three or four months he wished to try the effects of radio- and chemotherapies. After some discussion of the problem with a psychiatrist he addressed himself to the patient as follows: to his surprise, when examined under the microscope the tumor in her abdomen proved to be cancerous; he fully believed he had removed it entirely; to feel perfectly safe, however, he intended to give her radiation and chemical therapies over an indeterminate period of time. The patient was highly gratified by his frankness and proceeded to live for nearly three more *years*, during which time she enjoyed an active and productive life.

A rather similar approach was utilized in the case of Winkelstein and Blacher, previously mentioned.[8] In the presence of his wife the patient was told by the resident surgeon, upon the advice of the psychia-

trist, that the biopsy of the cervical node showed cancer; that he had a cancerous growth in the abdomen; that it was the type of cancer that responds well to chemotherapy; that if the latter produced any discomfort he would receive medication for its relief; and finally that the doctors were very hopeful for a successful outcome. The patient who, it will be recalled, had declared he wouldn't want to live if the doctors found cancer, was obviously gratified. Immediately he telephoned members of his family to tell them the news, gratuitously adding that the tumor was of low grade malignancy. That night he slept well for the first time since entering the hospital and he continued to do so during the remainder of his stay. Just before leaving he confessed that he had known all along about the existence of the abdominal mass but that he had concealed his knowledge in order to see what the doctors would tell him. Upon arriving home he wrote a warm letter of thanks and admiration to the resident surgeon.

It should be emphasized that although in both of these instances the advice of a psychiatrist was instrumental in formulating the discussion of the facts of the illness, it was the surgeon, not the psychiatrist, who did the talking. The importance of this point cannot be exaggerated, for it is the surgeon who plays the central and crucial role in such cases; it is to him, and not to some substitute, that the patient looks for enlightenment and for hope. As noted earlier it is not every surgeon who can bring himself to speak in this fashion to his patient, and for some there may be a strong temptation to take refuge in a stereotyped formula, or to waive responsibility altogether. The surgical resident, in the last case cited, for example, was both appalled and distressed when he was advised what to do. Yet he steeled himself, looked the patient straight in the eye, and spoke with conviction. When he saw the result he was both relieved and gratified. Indeed he emerged from the experience a far wiser man and a better physician.

The point of view expressed in the foregoing pages has been espoused by others in considering the problem of communication with the dying patient. Aldrich stresses the importance of providing such persons with an appropriately timed opportunity of selecting acceptance or denial of the truth in their efforts to cope with their plight.[2] Weisman and Hackett believe that for the majority of patients it is likely that there is neither complete acceptance nor total repudiation of the imminence of death.[7] "To deny this 'middle knowledge' of approaching

death," they assert, "is to deny the responsiveness of the mind to both internal perceptions and external information. There is always a psychological sampling of the physiological stream; fever, weakness, anorexia, weight loss and pain are subjective counterparts of homeostatic alteration. . . . If to this are added changes in those close to the patient, the knowledge of approaching death is confirmed." Other observers agree that a patient who is sick enough to die often knows it without being told, and that what he seeks from his physician are no longer statements concerning diagnosis and prognosis, but earnest manifestations of his unwavering concern and devotion. As noted earlier it is at such times that for reasons of their own psychological make-up some physicians become deeply troubled and are most prone to drift away, thereby adding to the dying patient's suffering—the suffering caused by a sense of abandonment, of isolation, and of emotional deprivation.

In contrast it should be stressed that no less potent than morphine nor less effective than an array of tranquilizers is the steadfast and serious concern of the physician for those often numerous and relatively minor complaints of the dying patient. To this beneficent manifestation of psychological denial, which may at times indeed attain hypochondriacal proportions, the physician ideally should respond in kind, shifting his gaze from the lethal process he is now helpless to arrest to the living being whose discomfort and distress he is still able to assuage. In these, the final measures of the dance of life, it may then appear as if both partners had reached a tacit and a mutual understanding, an unspoken pledge to ignore the dark shadow of impending death and to resume those turns and rhythms that were familiar figures in a more felicitous past. If in this he is possessed of enough grace and elegance to play his part, the doctor may well succeed in fulfilling the assertion of Oliver Wendell Holmes that if one of the functions of the physician is to assist at the coming in, another is to assist at the going out.

If what has been set down here should prove uncongenial to some strict moralists, one can only observe that there is a hierarchy of morality, and that ours is a profession which traditionally has been guided by a precept that transcends the virtue of uttering truth for truth's sake, and that is, "So far as possible, do no harm." Where it concerns communication between the physician and his patient the attainment of this goal demands an ear that is sensitive both to what is

said and to what is not said, a mind that is capable of understanding what has been heard, and a heart that can respond to what has been understood. Here, as in many difficult human enterprises, it may prove easier to learn the words than to sing the tune.

> We did not dare to breathe a prayer
> Or give our anguish scope!
> Something was dead in each of us,
> And what was dead was Hope!
>
> Oscar Wilde: *The Ballad of Reading Gaol.*

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