Doctors and the truth

Talking drums: doctor–patient communication in a complex world. Shima Gyoh on the trials and tribulations of dealing honestly with patients who are often more used to dealing with their traditional healer

The doctor's code of ethics require that he must be truthful at all times but, do patients, particularly in Africa, always want the truth? No-one would admit that they would rather the doctor lied to them. It is obvious that truth is sweet when the news is good or hopeful. When the news is depressing or frightening, the story is not always consistent.

Informing our uneducated patients presents a peculiar but common problem for doctors whose services cover rural dwellers that speak only their ethnic dialect. The vernacular often lacks the words the doctor needs to explain the condition properly, simply because many scientific words do not exist in African languages. There is need for the development of vernaculars and adoption and adaption of foreign terms to expand their lexicon to cope more comprehensively with modern knowledge, particularly in science. The doctors need to coin new medical terms in their mother tongues to describe medical conditions, at least for future generations. This is not happening to any appreciable extent. Rather, many African languages are slipping down a steep slope on their way to the trashcan of history.

Psychosomatic illnesses form the bulk of complaints doctors see in general outpatients' clinics. They require a lot of time for counselling, sometimes combined with prescriptions. The traditional doctor, whose practice is less regimented, has a lot of time for his patients, and infuses confidence through reassuring rituals. His success in these types of complaint sustains his popularity, despite frequent failures in treating organic disease. The orthodox doctor, having a conveyor-belt-like busy outpatients' clinic cannot afford long periods with each patient. He compensates for this by prescriptions, and his failure in these complaints tends to taint his relative success in organic disease. Few African patients tolerate being told that their complaints are psychosomatic. They will vehemently protest that they are 'not imagining things.' Referral to a psychiatrist is often rejected because the term for a psychiatrist in most ethnic dialects is 'doctor for mad people.'

It is possible to resolve neurotic problems by following the example of the traditional doctor – you must ooze confidence and make the patient believe that you have all the answers. I know of a colleague who cured impotence by injecting normal saline, while boasting that it was a very powerful medicine that would clear the condition in no time. It often did, and he had many grateful patients. This is basically dishonest, but does the end justify the means? Should he stand condemned for making a man happy with a harmless lie? The alternative would have been referral to another doctor where there might have been drug prescriptions and several counselling sessions over weeks or months, with the embarrassing request to involve his wife.

In another story, an educated patient, a superintendent of police, complained that his enemies had planted a powerful charm in his perineum; it was causing him ill health, bad dreams, impotence, and lack of drive. The doctor did not find any lesion after careful examination and a wide range of investigations. He tried to cure the policeman's neurosis by scientific education and counselling, but the policeman felt it was the doctor that needed proper education on matters of the occult. In the end, the doctor decided to play along. He did a small incision under local anaesthesia and then sutured it, telling his patient that he had taken out a small 'sebaceous cyst.'

'That is it! I knew it was there!' the policeman cried in triumph. 'You have a medical name, but that is the charm my enemy planted! Thank you very much!' He went home in high spirits, determined to stop a repeat attack through intense prayers – a curious admixture of religion and superstition, the identical twins of our emotions.

No patient wants to be kept in the dark, but the fear of bad news sometimes supresses the wish to know the truth. It is also common knowledge that the traditional doctor, who does no scientific investigation, is popular mostly because he oozes confidence and gives a bright prognoses in nearly all cases; his ignorance underwriting his honesty. It cannot be the same with the orthodox practitioner who has better knowledge of the conditions he manages. The odd fact is that the traditional doctor's rosy prognosis in terminal illness sustains the morale in the family and the patient right to the end. The orthodox doctor must develop the skill of delivering distressing truth with minimal demoralisation.

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