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Informed Consent and Truth in Medicine

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THE DATA presented by Williams and Zwitter [1] are of utmost importance. First, because of their honesty in reporting the actual situation as far as informed consent in clinical research is provided in different European Countries. Second, because they quantify what had been previously described only anecdotally.

Facing the pluralism of multiethnic modern societies, and the shift of the patient–doctor relationship from a paternalistic to a more contractual model, the issue of truth-telling and of cultural influences on it [2,3] is indeed pressing. While observation of differences is the initial step, philosophical foundations must be explored as a way to a deeper understanding of the problem and of the role of physicians.

What is truth is a meta-ethical problem, but ethics—a practical philosophy [4]—is constantly confronted with truth/truths. Is there only one truth or are there truths? Is truth merely the opposite of—or the absence of—a lie or is truth a relational state?

Pluralism is a *de facto* reality and an essential principle of democracy: it should not lead to the intrinsic pessimism of cultural relativism, whereby the ethical debate is paralysed. On the contrary, pluralism enriches ethics by adding a dimension of the non-repeatibility of values, always expressing themselves within defined contexts, and by fostering historical concreteness [5]. There are common principles [6,7], whose expression can be influenced by cultural differences: truth-telling stems from a balance between autonomy and beneficence. Where autonomy is synonymous with freedom—the U.S. for instance—truth-telling is possible and beneficial. Where autonomy is synonymous with isolation—Mediterranean countries for example—truth-telling is certainly more difficult. Autonomy and beneficence are not antagonistic, but rather interdependent principles.

When perceiving truth as only the opposite or the absence of lie, we imply that truth is a fixed object merely needing to be described/verbalised. In medicine, truth equals information. When perceiving truth as a relational state, we imply that truth develops, in time and space, because of interactions: in medicine this happens between the patient, the disease, the doctor, the family, the society and the medications. Truth goes beyond information and reaches the level of communication, a bidirectional process by definition. Communication is the real goal.

So should we be simple spectators, or should we not become actively involved in fostering the development of a more truthful patient–doctor–society relationship? Bioethics [8] can also be an instrument for participation in the development of better societies. Within this perspective, I am concerned at permitting insufficient information being given to the patient, whether it is in or outside the context of research protocols [9] since a profoundly humane patient–doctor relationship can arise from accurate, continuous and open information–communication, whereby the doctor is at the same time the expert and the educator, in no way delegating the burden of responsibility to the patient.

The findings of Williams and Zwitter [1] make us aware of a reality, as well as of the need to modify it for the best: in this case, by increasing the level of patients' autonomy without giving up beneficence.

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