
FROM THE EDITOR

Is House, M.D., always right?

Gregory House, M.D., stated in one of his memorable if misanthropic aphorisms, that patients lie. “I don’t ask why patients lie, I just assume they all do” (Moran & Spicer, 2004). This is true. On the other hand, the patient, like the customer, is always right. This is also true. Reconciliation of these aphorisms leads us some way to understanding the art of medicine and the tribulations of palliative care.

Ninety percent of our consultations as a pain and palliative care service in a comprehensive cancer care are for pain (Pain and Palliative Care Service). Patients are constantly “lying” about their pain: They exaggerate, minimize, or are incapable of providing a textbook description.

A patient was referred with a large mass in his pelvis eroding the sacrum. He appeared to be in pain and could not even lie flat for his scans. When asked how bad his pain was he demurred indicating he could cope and the chemotherapy would fix it. Eventually we convinced him to take the appropriate analgesia, the pain was relieved, and he was a new man. Why did he lie?

There are many reasons patients minimize—or are deceptive about—their pain: through fear of disease recurrence or progression, a need to be stoic or heroic, a fear of medications (especially of opioids), and a wish to please the doctor.

Similarly, patients may exaggerate—though not fabricate—their pain: in fear they will not receive adequate attention, as an expression of psychological distress or spiritual angst, due to personality traits, and the influence of cultural norms.

Patients do not lie out of dishonesty; rather they mislead for psychosocial reasons. If we as healers subscribe to Engel’s (1977) bio-psycho-social model, then we will interpret the complaint through the prism of context. We will not simply ask the patient to complete the visual analogue scale of pain and prescribe accordingly. Rather we will watch and

listen to how the patient reports the symptoms. While asking about the pain, we will enquire about their lives—who they are, where they live, what their views are about single-malt whiskeys. All the time in the back of the mind making a psychosocial overview as a prelude to the medical assessment.

Engel, a psychiatrist from New York, wrote a seminal paper in 1977, published in of all journals, *Science*. (His paper was followed by an article on how to identify “complex precipitates in steel.” The dissonant juxtaposition is telling.)

Engel decried the notion that disease is defined as a “somatic” disorder and that psychosocial issues are no longer part of the clinician’s sphere of responsibility. He thought this artificial split adversely influenced doctors’ attitudes to patients and families. Engel quoted one authority who called for a “disentanglement of the organic elements of disease from the psychosocial elements of human malfunction” (Engel, 1977).

The biomedical model, Engel noted (1977), “embraces reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic.” To say that patients “lie” is to be “reductionistic” in the sense that Engel bemoaned. Infrequently is there a unitary objective scientific truth in clinical medicine. There is the illness and the patient who has the illness. The patients—with their psycho-social makeup, influence both the diagnostic process and the management. Thus, if a biopsy confirms lung cancer, then lung cancer it is. However, the patients’ personality and culture play a big part in bringing them to the biopsy (early or delayed) and later, choosing which treatment, when to stop, how to die, and so forth.

A patient presents with thalidomide-induced peripheral neuropathy. The electromyographic studies and linear-analogue pain scales alone will not tell me whether to start medications. Rather, by careful listening will we discover that the patient is more frightened about the significance of the pain and not that the pain is so significant. A detailed

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explanation of the mechanisms and time course of the neuropathy allows a relieved patient to go home, doubly relieved at not being prescribed yet another tablet. The “psychobiological unity of man” (Engle, 1977) means we must be able to evaluate the interrelationship between pain and anxiety.

The patient is always correct (even if he or she is not telling “the truth” from a medical-diagnostic perspective) in the sense that anxiety, anger, and fear are medical issues. They may be an existential response to a terminal illness or even part of a physical syndrome, such as dyspnoea. The anxiety—usually terror of death—sets in train all sorts of psychological coping mechanisms and defenses, some of which manifest as “mistruths.” They are not lies. Like a dream or a neurosis or a physical symptom, there are rational explanations. These explanations enable the practitioner to understand the deceptions and to realize they are part and parcel of the doctor’s purview of care.

Clearly there is a limit to tolerance. Violence, personal abuse, and their ilk will mean that, in certain situations, the customer is not right and should be evicted from the store. In oncology and palliative care this is a rare occurrence.

A patient who is treated as an object of pain is an example of Engel’s reductionistic concept. Woodruff (2003) makes the point that, rather than focus on a diagnostic pain syndrome; it is preferable to think about “the patient suffering.” Suffering includes pain, cultural, psychological, and spiritual issues. In addition, he emphasizes the interdependence between the factors that produce suffering. Unrelieved pain may accentuate anxiety and personality difficulties, whereas psychosocial issues may exacerbate dyspnoea, pain, and their expression.

A brief etymological diversion illustrates this point. The Phoenicians, a sea-faring people from the northeastern Mediterranean, first introduced to Europe about 1000 BCE the concept of the alphabet—the precursor, via Greek and Etruscan, of Latin. The written languages of Phoenician (now extinct) and Hebrew are the same (Robinson, 2007). The Hebrew root word *s-v-l* is common to the Hebrew words for *suffering* and *patience*, indicating similar core meanings. In English, as derived from Latin, a similar sense is retained by the Latin root *pati*, which means to suffer or to endure. Hence, the double entendre in the words *patient* and *patience*, and the well-known expression, “with the patience of Job.”

How can we help ourselves to help our patients? I find it helpful to second-guess patients and

challenge their prejudices and fears; more often than not they appreciate the information and accept help.

Collateral evidence is vital. I well recall a middle-aged family physician with pancreatic cancer. He described classic celiac plexus pain. Initially he responded well to gabapentin but minimized his pain and was reluctant to add opioids despite disease progression. He only allowed opioids preterminally. After the funeral, word filtered back that friends were appalled at the severity of the pain, and that it could not be controlled. He had lied to me and I had believed him. In retrospect the diagnostic clue to his “malingering” was the distress on his wife’s face which I saw from the corner of my eye and assumed (incorrectly) was due to existential distress. I should have taken her aside and asked “How are things?”

Speaking with family members—with the patient’s permission—is an important part of the psychosocial history and oftentimes the physical history as well.

Engel’s take-home message is twofold: first, that it is nonfactual to view consciousness and flesh as concretely separate entities and, second, that one cannot be the complete physician without considering the bidirectional interplay of physical and psychosocial factors.

The development of palliative medicine and psychooncology as separate oncology specialties speaks eloquently about how seriously the health-care professions have taken Engel’s challenge to heart.

Gregory House, M.D., was wrong.

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