THE RIGHT TO THE TRUTH ABOUT THE LATEST DIAGNOSIS

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Diagnoses made during the diagnostic process are often disappointing and raise the question of whether and how to communicate them to the patient. Diagnoses have complex characteristics, but the ethical criterion of personality status is not always taken into account.

All over the world, but especially in our country, there is a long tradition of not informing seriously ill people about their diagnosis. This practice causes regret about the psyche of a patient who has been in an unstable state for many years due to poor health.

Modern legislation does not dare to put an end to this problem. Doctors, friends and relatives can be informed about the fatal diagnosis, but the patient remains in the dark until the last moment. In such cases, there is an ethical conflict around advantages and disadvantages. Psychologists, doctors, deontologists and other experts are trying to resolve this issue.

At the same time, two aspects of this problem are balanced:

- The right of a person to know what is happening to him;
- Such knowledge is characteristic of our culture, which has a strong fear of death.

The solution of these issues often remains on the conscience of the doctor. In many areas of medicine, patient awareness is one of the conditions for successful treatment. If patients know the diagnosis, they can "help" medical professionals by providing the right treatment outside the medical center. In this way, a proper lifestyle can be organized that promotes recovery. However, doctors are often afraid to tell patients about terrible diagnoses, as this can damage their spirit.

However, patients over the age of 14 have the right to a full explanation of their state of health, as well as the diagnosis, but often they do not receive direct answers to their questions.

Patients' reactions to the doctor's message about the presence of a fatal disease can be varied. Elizabeth Kubler-Ross in the book "On Death and Dying" describes the patient's reaction as a sequence of stages.

THE 1ST STAGE: denial and isolation.

Such an initial denial is inherent in both patients who were told the truth at the very beginning of the development of the disease, and those who guessed the sad truth on their own. Denial – at least partial – is inherent in almost all patients, not only in the first stages of the disease, but also later, when it manifests itself from time to time. Denial plays the role of a buffer, mitigating an unexpected shock. It allows the patient to collect his thoughts, and later use other, less radical forms of protection. Denial is most often a temporary form of protection and is soon replaced by partial humility.

THE 2ND STAGE: anger.

The first reaction to the terrible news is the thought: "It's not true, this can't happen to me." But later, when a person finally understands: "Yes, there is no mistake, it really is," he has a different reaction. Fortunately or unfortunately, very few patients are able to cling to a fictional world until the very end, in which they remain healthy and happy.

When the patient is no longer able to deny the obvious, he begins to be overwhelmed with rage, irritation, envy and resentment. The following logical question arises: "Why me?" In contrast to the denial stage, it is very difficult for the patient's family and hospital staff to cope with the stage of anger and rage. The reason is that the patient's indignation spreads in all directions and sometimes splashes out on others completely unexpectedly. The problem is that only a few people try to put themselves in the place of the patient and imagine what this irritability can mean. If the patient is treated with respect and understanding, given time and attention, the tone of his voice will soon become normal, and irritated demands will stop. He will know that he remains a significant person, that they care about him, want to help him live as long as possible. He will understand: in order to be listened to, it is not necessary to resort to outbursts of irritation.

THE 3RD STAGE: trading.

The third stage, when the patient tries to negotiate with the disease, is not so well known, but nevertheless it is very useful for the patient, although it does not last very long. If at the first stage we could not openly admit the sad facts, and at the second we felt resentment against others and against God, then perhaps we will be able to come to some kind of agreement that will delay the inevitable. A terminally ill patient resorts to similar techniques. From past experience, he knows that there is always a faint hope for the reward of good behavior, the fulfillment of desires for special merits. His desire almost always consists first in prolonging life, and later is replaced by hope for at least a few days without pain and inconvenience. In essence, such a deal is an attempt to delay the inevitable. It not only determines the reward "for exemplary behavior", but also establishes a certain "final line" (another performance, a son's wedding, etc.). From a psychological point of view, promises can indicate a hidden sense of guilt. For this reason, it is very important that hospital staff pay attention to such statements of patients.

STAGE FOUR: depression.

When a doomed patient can no longer deny his illness, when he has to go to another operation or hospitalization, when new symptoms of the disease appear, and the patient weakens and loses weight, you can no longer dismiss sad thoughts with a careless smile. Stupor or stoic attitude, irritability and resentment are soon replaced by a feeling of great loss. Intensive treatment and hospital stay are compounded by monetary expenses, since not all patients can afford luxurious conditions at the beginning of treatment, and then basic necessities. The causes of depression are well known to anyone who deals with patients. However, we often forget about the preparatory grief that a terminally ill person experiences when preparing for the final farewell to this world. A sensitive person can easily identify the cause of depression and relieve the patient from unjustified feelings of guilt, which often accompanies depression.

THE FIFTH STAGE: humility.

If the patient has a lot of time at his disposal (that is, we are not talking about sudden and unexpected death) and he is helped to overcome the stages described above, he will reach the stage when depression and anger at the "evil fate" recede. He has already thrown out all his previous feelings: envy of healthy people and irritation with those whose end will not come soon. He has stopped mourning the imminent loss of loved ones and things and now begins to reflect on the impending death with a certain degree of calm expectation. The patient feels tired and, in most cases, physically weak. Humility should not be considered a stage of joy. It is almost devoid of feelings, as if the pain is gone, the struggle is over and it is time for "the last respite before a long journey," as one of the patients put it. In addition, at this time, the patient's family needs help, understanding and support more than the patient himself. Most patients died at the stage of humility, without experiencing fear and despair.

HOW SHOULD AND SHOULD NOT BEHAVE WITH A DYING PATIENT:

1. Do not take a hard line, for example: "In such cases, I always inform the patient." Let the patient be a guide. Many patients want to know the diagnosis, while others do not. It should be found out that the patient already knows about the prognosis of his disease. Do not deprive the patient of hope and do not convince him if denial is the main defense mechanism, as long as he can receive and accept the necessary help. If the patient refuses to accept it as a result of denying his illness, in a mild form and gradually let him understand that help is needed and will be provided to him. Convince the patient that care for him will be shown regardless of his behavior.

2. You should stay with the patient after informing him about his condition or diagnosis. After that, the patient may experience a strong psychological shock. Encourage him to ask questions and give truthful answers. Say that you will be back to answer questions from the patient or his family. If possible, you should return to the patient after a few hours in order to check his condition. If the patient has significant anxiety, he can be prescribed 5 mg of diazepam (valium) possibly for 24-48 hours.

3. Advice should be given to the patient's family members regarding his illness. Recommend that they communicate with the patient more often and allow him to talk about his fears and experiences. Family members will not only have to face the tragedy of losing a loved one, but also with the realization of the thought of their own death, which can cause anxiety.

4. The pain and suffering of the patient should be relieved.

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