AIDS and Truth

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We see the AIDS epidemic first and foremost as exposing a crisis which goes beyond it and which emphasises how urgent and exacting is the challenge facing us all: the challenge to become, both personally and collectively, the subject—or subjects—of our own history.[1]

In approaching this subject, clarification of the obscure relations between AIDS and the question of truth plays an indispensable part. That is why we desire to return to it by tackling it from the angle of the patient/practitioner relationship.[2] This offers us the advantage of a concrete approach to the question of truth and AIDS without exempting us from facing the question at the deeper level of an analysis of our desire to control everything. Also it enables us to stress the close bonds which link this question of truth with that of *deficiency*.

1. From one recipient to another?

The patient-practitioner relationship is a particular instance of human relationship in general. It also can be subjected to the same fundamental ethical analysis. As we have shown elsewhere,[3] no true human relationship is possible if those involved do not fulfil the following three conditions: to be *present* to one another, to accept their *differences* in fact, and, above all, to cultivate their moral *equivalence*. But their moral equivalence would be denied by one lying about the other. Why, in fact, pretend to recognise another person as morally your equal if, by hiding the truth from that person, you seal him or her up in a lie?

The *forbidding of lying*[4] is, then, fundamental to the truly human relationship, as much as is the forbidding of homicide (how, indeed, am I able to cultivate the humanity of another person if I would permit myself to wipe that person out?) and the forbidding of incest (how, indeed, am I able to cultivate the autonomy of another person if I would permit myself to impose on that person sexually?).

But how can the forbidding of lying be preserved in the patient-practitioner relationship? When our students in the Faculty of Medicine put this question to us, we ask them to ponder on the following practical suggestions:

— when a patient asks questions, take time listening to him;
— then, reply to his questions;
— when you reply, never lie, for that would dehumanise the patient

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(but not lying does not necessarily mean burdening the patient with an unbearable truth);

— try, therefore, to end each of the replies (which are possibly *partial replies) with a quiet invitation to the patient to put the next* question.

Frankly, no-one knows better than the patient himself how much he is able to bear. So it should be he, not the practitioner, who takes the initiative in the conversation. Besides, the truth is in no case like a liquid that the practitioner is able to pour more or less complete out of of his mental container into the patient's mental container.

In medicine, the truth is always multiple. There is prophylactic truth, which very often is quite well established; so, in the case of AIDS, medicine teaches us some technical truths regarding prevention which are beyond dispute (even if their application by the majority of people stays problematic). There is diagnostic truth, which is able to be, in certain cases, fairly reliable; in the detection of infection by the HIV virus, you can now use a test which enables you to make a practically certain diagnosis. There is prognostic truth, which is for the most part very uncertain. What truth can you tell a perspm who is HIV Positive about his future? Nothing precise: 'The likelihood of contracting AIDS is high, but it is not absolutely unavoidable', etc. And yet what in reality interests the patient is the prognosis much more than the diagnosis.

You can, however, ask yourself whether, in the case of a patient being HIV Positive, the practitioner does not have a duty to put the patient's social *responsibilities in front of him, not content himself* merely with telling the patient what he thinks he can hear; that he should make him realise the foreseeable consequences of behaviour on his part not respecting the rules of prevention. The answer is obviously in the affirmative. And one must hope that such an honest relationship between practitioner and patient will encourage an honest relationship between the infected person and his subsequent partners.

2. The failure to control

These few remarks underline the fragility of medical certainties about AIDS: the explanation of the phenomenon remains broadly incomplete; its therapeutic approach, for want of sufficient scientific foundation, remains very much rule-of-thumb and problematic; in spite of the impressive mass of information gathered on the ways in which the virus is transmitted from one individual to another, the campaigns for prevention remain relatively ineffective for lack of a sufficiently profound analysis of the psycho-pathogenetic situation in which individuals are placed, being submitted simultaneously to commands of a preventative kind and erotic advertising.

But the fragility of medical certainties is not the only reason for our not mastering AIDS. Thus, respect for certain ethical rules, such as that of confidentiality, observance of which proves to be more vital than ever

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in the face of threats of totalitarianism, both technical and administrative, stimulates in some practitioners feelings of scandal, to the point that some have gone so far as to ask for release from the professional rule of secrecy when an infected person is known not to be taking necessary precautions to avoid transmitting the virus to others.[5] Such endeavours reveal an irritating desire to get everything under control at any price. The desire for control is doubtless not bad in itself, but it becomes corrupt every time that it is exercised to the detriment of higher values.

Undoubtedly it is one of the essential conditions of democracy that everybody is granted right of access to information concerning himself or herself and also right to control the use that is made of that information. Lack of respect for that fundamental principle leads to confusion between the roles of the *therapist* (whose mission is to protect the interests of the patient) and of the *policeman* (whose mission it is to protect the interests of society). The World Medical Association is itself guilty of that regrettable confusion.[6] We see here an indication of the difficulty experienced by the medical establishment in having to recognise that it is not totally in control of a phenomenon for the controlling of which it declares itself competent.

But it must be stated that if the threat that the epidemic imposes on humanity is of a collective type, it is the decisions (or, rather, the non-decisions) of individuals in the living out of the sexual expressions of their relational life which are responsible, for the most part, for the spread of the epidemic. The temptation, then, is great to demand the control of experience located in the sphere of private life in the name of imperatives relating to public life. However, not only would this task be impossible to acomplish, but the execution of it would be wholly self-contradictory, since it would ruin what it is being done in the name of: namely, democracy. The only truly human way of reacting consists in not lying collectively about our genuine possibilities (or, rather, impossibilities) of action; in other words, by beginning by recognising our powerlessness in the face of the scope of the drama.

3. The truth of deficiency

The ways of acting fail us because we fail in an action. It is because we hesitate to ask ourselves about the true significance of our sexual life that we are not able to discern the true ways of acting to fight the AIDS epidemic. What do we look for through our sexual life?

The hypothesis could be made that we are looking for something to fill in the deficiency inherent in every human condition. We are desperately seeking to escape from our solitude, our finiteness, our uncertainty. We want to *possess the certainty* of being desired only for ourselves, and thus overcome our radical solitude and preserve ourselves from running up against the limits which are the hallmark of our finiteness. In our sexual life we are seeking confirmation that we are not

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reduced to being only ourselves. And the object of that search always escapes us.

The eternal suffering linked to flight ahead of desire is emphasised today more than ever by the social ratification of the right to fulfilment of one's desire (the right to have a child, right to health, right to pleasure, right to wealth, right to take one's life ...), a right we demand without daring to ask ourselves who could legitimise the prescription for it.

This consciousness of right closes what it wanted to open: communication with the other. Indeed, it dominates all your capacity to open yourself to the other, who finds himself or herself reduced to an object in the field structured by your desire.

It is thus that we make impossible for ourselves the task which is the most humanly ours: to take on together the deficiency from which every one of us suffers.

This is one of the truths that a deep analysis of the problem of AIDS reveals to us—one which we are always ill-prepared to hear! It is, however, in the confronting of that truth that it would be possible to develop ways of teaching a sense of responsibility, not only regarding the risks linked to the transmission of the AIDS virus, but also, more broadly, in regard to the meaning of our relational life and of its eventual sexual expressions.

1 Cf. J.-F. Malherbe & S. Zorrilla, 'Le SIDA, révélateur de la crise du sujet', in *Le Supplément*, no. 170, Paris, September 1989, pp. 81—90.

2 Cf. J.-F. Malherbe & S. Zorrilla, 'Le citoyen, le médecine et le SIDA: l'exigence de vérité', *Catalyses*. CIACO, Louvain-la Neuve, 1988.

3 Cf. J.-F. Malherbe, *Pour une éthique de la médecine,* Larousse, Paris, 1987.

4 It has equally satisfactorily been called the forbidding of idolatry and the forbidding alienation.

5 Cf. for example the World Medical Association's interim statement on AIDS, adopted at Madrid in October 1987. Article 7 recommends that 'the identity of AIDS patients and carriers should be protected from disclosure except where the health of the community requires otherwise', without questioning the compatibility of such a recommendation with the rules of democracy nor even the real effectiveness of such a proposal.

6 Cf. note 1, p.3.

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