The houseman and the dying patient

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Editor’s note

The authors, a house physician and a house surgeon, discuss the relationship between dying patient and doctor in the light of their own experiences as analysed against the background of contemporary literature on the subject. Asking if the relationship can approach friendship they point to its intrinsic inequalities; they suggest that the psychotherapeutic relationship provides a somewhat better analogue. Discussing the controversy over whether or not to tell dying patients of their plight they indicate that this profound dilemma cannot be resolved—‘we must make our absurd judgment of whether they would want to know; and then act on it’.

This article is written by housemen in an attempt to explore relationships with patients where the routine of 1980s scientific medicine seems inadequate. We hope it may stimulate others to think about their approach when there is uncertainty about what should be told and what left unsaid.

Vague good intentions probably exist in most doctors and are part of their reason for choosing medicine as a career, but in a society which has largely left religion behind and lacks a coherent philosophy to take its place, there is little opportunity to discuss them without sounding sanctimonious. Hence the doctor has few guidelines to think through his approach to the patient as a person despite the recent encouragements to adopt it. In a situation where the ethics are difficult, the doctor has little to gain from leaving his good intentions subconscious. If he realises them at least he can work through their implications and attempt to apply them to the patient’s plight. His communication may then be more helpful; or less inadequate. As Jaspers (1) said, what is important in any theory or practice related to Man is that there should be ‘a basic philosophic attitude and no philosophical dogma’.

Historically, medicine was closely associated with religion. The junior staff of medieval British hospitals were sometimes priests or monks and sometimes laymen, and as much attention was paid to the spiritual well-being of a sick person as to the treatment of his physical disease (2). The massive advances in medicine since that time have changed everything except the fundamental position of the patient in hospital; but the now justifiable emphasis on investigation and cure has tended to obscure it. Illich (3) speaks very critically of the ‘medicalisation of the struggle against death’. That death has come into the province of medicine is not the individual doctor’s fault, but he does have a duty to cope with it. We feel there ought to be more we could do for dying patients, simply as helpers in a privileged position, but we are not sure what or how.

The houseman’s position is special for a number of reasons. Firstly, he sees the patient only in the context of his current disease, unlike the consultant who may have seen him before and the nurses who attend his ordinary needs. Secondly, he sees the patient for longer periods and more intimately than the more senior members of the team. Thirdly, he is the youngest of the team and the closest to being able to remember what it was like to have no knowledge of medicine. Fourthly, and perhaps most importantly, he is licensed to say (whether truly or because it is expedient) that he does not know, but that a more senior doctor will. This gives him very useful leeway. Nevertheless, he knows the results of investigations to hand and it is him the patient is likely to ask. Nurses rightly defer such questions. As a result, the houseman tends to be the most closely involved in what the patient knows and does not know about his illness.

The positions of doctor and patient

The literature on the doctor-patient relationship is extensive. We shall merely set out what we see as the parameters of the relationship and how they differ from those of other relationships.

Whatever exists between patient and houseman is firmly set in the objective reality of the hospital: its wards and treatment rooms, its curtains round the bed, its rounds. In the ‘clerking’, the houseman asks many standard questions and a few of particular relevance to that patient, and he then examines him more or less fully. After this, the houseman sees the patient one or more times daily, mainly in the course of seeing all his patients and occasionally when he allocates time to the patient. In this pattern, the course of investigations or treatment gradually unfolds and can be discussed between doctor and patient. The houseman has little time and his
devotion to the patient must fit into an overall routine of work. But whereas he can predict and prepare for these interactions, the patient rarely initiates them and hence has less chance to prepare, even though his personal perception of reality is the matter to be discussed.

Szasz and Hollender (4) set out three basic models of the doctor-patient relationship, according to whether the patient is a passive recipient of treatment, or is actively but dutifully obeying the doctor, or is seeking expert help on an equal footing. While these three types of relationship may clearly be distinguished, our interest here is in whether they are anything more than types of a business relationship. Would we be deceived in thinking we might form any kind of friendship?

Friendship in its ordinary sense is entered into by mutual desire and sanctions its partners each to know one another. The relationship between patient and houseman is not entered into by desire and is one-sided: the houseman looks into the patient’s social position and the condition of his body, whereas the patient knows only the houseman’s face and what personality he chooses to project. In its balance it is similar to the relationship between a psychotherapist and his patient. Lewis (5) contends that a general hospital has much to learn from this area; but the comparison is restricted because the houseman has far less time, because coming to know the personality is not his main brief, and because dealing with potentially life-threatening disease takes precedence in the claims on his resources.

In having access to the private details of the patient’s bodily condition, the doctor has a unique standing. He knows, or tries to predict, the course of the patient’s disease, his prognosis—almost his fate. This is an uncomfortable position. We sometimes feel we know more about our patients than one person has a right to know about another, gravely important things they do not know themselves. To proceed from here with any form of ‘human contact’ is awkward: to be business-like in our interactions is easiest and hides our doubts. But is this the best approach from the patient’s viewpoint? What if he sees more than we realise? Wilson (6) points out that patients notice when their questions are evaded and reassurance is not given, because we are so quick to give it when we can. He emphasises the impact of non-verbal communication of our attitudes and feelings. Given this, ‘human contact’ is unavoidable and to attempt to avoid it has a strongly adverse effect. Yet any attempt we might take to befriend the patient in the ordinary way is made hazardous by our lack of time—compared to the lengths of time he has—and the taboos imposed by our knowledge of his disease.

Let us consider the houseman’s side of the relationship. If medicine is in a state of crisis in failing to deal with the problems created by society’s attitudes towards it (7), the houseman stands in the front line. He experiences the crisis in the form of large numbers of patients being admitted with conditions that were once treated at home but now require investigations and treatment with a technology that has recently come into existence. His paperwork has likewise increased and while he may not want credit for simply talking to his patients, he is blamed if the results are not to hand or the records not written. Bennet (8) discusses the ‘need to be a doctor’. He hints, and our experience concurs, that those who go into medicine are at least as insecure and selfish as everyone else; but there is a need to show beneficence, regardless of whether this need reflects an irrational urge or a rational ethic (9), a need to feel we are doing something worthwhile. Thus the houseman is frustrated in his desire to talk to the patient from day to day and is only likely to find time when he has something important to say.

The patient’s side is very different. As we have said, for him the meetings are at unpredictable times, in a strange setting, with his existence in threat. He has not the houseman’s experience of what sort of things are said in communicating delicate news. The meetings are crucial to him in providing information about his future.

Our problem of course is cases with a poor prognosis: good news is easily and gladly communicated. But what is the patient to think when he receives no news? He must wait, each day hoping for some concrete encouragement and receiving only vague platitudes. Meanwhile his condition gets no better or deteriorates. In these circumstances, he must sense what is going on. Might it not be better for the houseman simply to tell him, and clear the air? But to be told one is going to die, and roughly when, must be awful. Often what happens is a mutual process of edging away from the subject, which neither stops the patient from realising that he is dying nor allows the doctor to reassure him over fears which could be allayed. The conversation follows the lines of least resistance unless the patient definitely asks for information or the houseman positively presses it.

We shall return to this issue. Here we simply wish to note the existential gulf between doctor and patient in their views of the disease, such that for one to judge how the other feels about it is necessarily absurd. Yet the doctor is forced to make such judgments if he is to deal with the situation at all.

The concept of death

We cannot know whether death is a complete ending of life or the start of some form of eternal life. Over the centuries popular belief seems to have changed from the latter to the former, at least ostensibly. This view is depressing and leaves us
very little to say in facing it; on the other hand the concept of eternal life is, we feel, ensconced in religion and not available to the doctor for discussion either. Cramond (10) remarks that in his experience patients seem to be equally divided between the two views; however, their beliefs do not alter patients' outward reactions as much as one might expect them to, perhaps for three reasons. First, all authors we have read on the subject are agreed that patients do not fear being dead anything like so much as they fear the process of dying. Second, whatever one consciously 'believes', one's moods and subconscious are orientated towards life as one has known it before. Third, few people today would profess an absolute faith even of their conscious selves. Jung, on the basis of an admittedly skewed sample, (11) reported that every one of his patients had 'the feeling that our religious truths have somehow become hollow'.

The decline of religion is of great importance not only in what the individual patient thinks but in the way society as a whole regards death. Without religion to portray it as a positive event, one which might even be celebrated, it becomes taboo — swept out of sight, not to be talked about. This adds to the isolation of dying. Pond (12) says that if the fundamental experiences of birth, death, bereavement and suffering are not capable of being symbolised in our society, we lose our 'essential humanity'. He contends that the important failure of religion today is in not providing a dynamic, creative view of human nature which balances its 'dark side'. Society has failed to reconcile its scientific and religious outlooks; religion has failed to adapt to society's new vocabulary and knowledge, so that what it was attempting to convey, whether divine or merely an attempt by Man to glimpse God and come to terms with existence, remains trapped in the old words.

Thus what we can say to the patient is limited. Obviously a good move is to call the chaplain and we are not seeking to take his place, but for much of the time the person present when the patient is facing death is the doctor. We see his reactions very much from the outside. Kubler-Ross (13) describes a progress from denial and isolation to anger, bargaining, depression and finally acceptance. Hinton (14) mentions how the sense of isolation contributes to the depression. The extent to which a patient can deny the knowledge that he is dying is remarkable. Brewin (15) states that the doctor can adapt his explanations to this; a very incomplete one may satisfy the patient where a methodical one will not. The doctor is in a position from which he could give useful support. He could alleviate the isolation because the patient may accept that the doctor knows him, in all his misery, though he hides from his family and friends. The actual process of dying is something the doctor does know about, and given that it is this the patient primarily fears, there is, in theory, much that could usefully be discussed.

There are two dangers, one on either side of this ideal. On the one side, the houseman may be shy of intruding on the intensely personal experience of the patient's death. On the other, if discussion does reach the vital issues he may not have time to carry the relationship through properly. Cramond (10) observes that its intensity is such that one special therapist should not be involved with more than two patients at a time. These problems in allowing the patient to discuss death when he knows it is near would be less if Cramond's therapists, or special care nursing officers (16), were employed by more hospitals.

Communication of the prognosis

The foregoing presupposes that the patient knows his diagnosis. But it is in the question of whether a bad prognosis should be communicated that the issues come into focus. Is it the patient's 'right' to know the prognosis as well as his doctor does? The answer depends upon whether doctors are to assume the responsibility of deciding the patients' best interests for them, or whether they are merely to stand alongside their patients in service. If the latter, we ought to tell patients as quickly and decently as we can, despite all the difficulties. Only if our individual patient consents to the former are we entitled to room to manoeuvre; and how are we to judge that he consents?

This dilemma is often resolved by telling the nearest relative the prognosis and asking her whether she thinks the patient would want to know himself. Although the relative should know the patient better, it may be that she can't answer the question and that she should not be burdened with it. If the relative is told and the patient is not, the knowledge must form a barrier between them. It is a dilemma inherent in a medicine which offers care indistinct from cure.

Withdrawing the hope of cure is shocking; we have so little to offer in its place. What is to be gained from doing it quickly? First, honesty is our moral norm. Second, to allow our patient to face the truth as far as we can predict it may enhance his sense of personal autonomy. We have dealt with one patient who felt positively enriched after being told that his laparotomy revealed carcinomatosis; Brewin (15) mentions such a case; certain of the Buddhist religions emphasise it and take great care to ensure the purity and concentration of the mind at the moment of death (17). Quint (18) shows how many cancer patients feel better able to cope when told bad news than when worrying about the unknown. On the other hand, as Brewin (15) says, one hesitates to knock down whatever defence the patient has erected. Furthermore, our predictions are often very inaccurate. Parke's (19) found that when doctors
and nurses predicted in private how long terminal patients would survive, over half the predictions were wrong by more than 50 per cent (and 85 per cent of the errors were over-optimistic).

Should we value the truth so highly, especially when we cannot get it right? Fletcher (20) says the best policy at the time of diagnosis is to tell both patient and family 'the most optimistic possible version of the perceived facts' and then to allow the patient to 'become adjusted as the prognosis becomes clearer'. Following this plan, the houseman would only take on the first stages of the communication, unless the patient has little time to live when the diagnosis is made. In the latter case it would be difficult to condense a gradual realisation into the short time available, and any attempt to communicate the prognosis in stages would engender an atmosphere of uncertainty. McIntosh (21) explores this problem.

The other possibility is for the patient to die unaware that he is dying. In our experience this happens not uncommonly. The patient may not ask if his operation has been successful, or his disease may progress insidiously, without the subject of death arising. As we have said, some patients sense that they are dying, but with others we feel that unless we press the news, they will not know. Thus we must make our absurd judgement of whether they would want to know; and then act on it, irrevocably. Bewin (15) suggests a useful technique is to begin a limited explanation and to watch carefully the patient's reaction, particularly his second question—or lack of a second question. One may discover other helpful moves in the course of experience. But however well those appear to suffice, they cannot resolve one of the most profound dilemmas in human communication today.

References

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