

Quoist (1971) wrote: 'A person's greatness is to be measured by his/her capacity for communion with others.'

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Commentary

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Dr Michael Wilson has cogently argued the need for better communication between doctors and patients when approaching death. I wish to consider briefly five practical questions.

Why don't we talk?

There seem to be four reasons. The first is that we are accustomed to treating our patients successfully with the increasingly powerful tools that medical science has placed in our hands. We tend to be so busy doing this in hospital that we resent the challenge of turning aside to help our failures. This 'action-orientation', which gives all forms of communication a low priority in our scale of values, is particularly inhibitory when there is little that we can do in physical terms. We tend, as Michael

Wilson has said, to pass by the end of the bed, with an embarrassed nod or a brief word of unconvincing encouragement, to a detailed discussion of the next recovering patient, thereby increasing the loneliness and the sense of neglect of the dying. The second is that talking to the dying is costly in time and is emotionally demanding. Cramond (1970) considers that 'any one therapist [he is speaking as a psychiatrist] cannot or should not be in such an intense relationship with more than two dying patients at any one time'. Thirdly, we have little or no training to fit us to deal with the many complex issues, emotional and spiritual, presented by communication with the dying. Finally, in spite of, or even because of our close daily acquaintance with death, we tend in self protection to look upon it as something which happens to patients and not to ourselves, something from which we want to keep ourselves separate. But no one can give support and comfort to the dying until he himself is fully reconciled to his own inevitable death.

When should we talk?

The simplest answer is 'when our patient wants us to talk', but he must be helped. Left without encouragement, he may never ask or may not be willing to unburden his fears until or unless we have obtained a close relationship and can provide an opening. We should not delay communication unnecessarily. Parkes (1973) described how patients need to be prepared for bad news and be introduced to it gradually. He has found that doctors and nurses tend to underestimate how much time is left for talking to dying patients.

Hinton (1963) emphasizes that 'there are occasions when a patient experiences anguish, ineffectively trying to thrust out the fear that he may die, but yet vaguely aware that he may need to accept the possibility. Leading the patient into talking of this, and not denying the situation, enables an adjustment to take place with less distress.'

The opportunity may arrive at the end of a careful examination; it may be given by just sitting and waiting in silence or by a simple question such as, 'Perhaps you have been wondering how seriously ill you are?', or 'I expect you are pretty worried by this illness?' Whenever it is done, the opportunity should be given since many patients who are dying recognize this but have to face this possibility alone, in hospital. It is quite wrong, as Michael Wilson has emphasized, that they should be isolated from the comfort of their families at this time.

Not all patients wish to discuss or recognize their coming death and we must respect their reticence. We have to remember that the patient's family may be as distressed as the patient, with feelings of guilt, fear, or resentment. Time must be given to help them too so that they may be better able to help the dying patient.

Who should talk?

Whoever first talks should know the patient well. This will usually be a member of the patient's family, or, if they cannot face the task, the general practitioner, but in hospital, to quote Cicely Saunders (1959), 'The final responsibility lies with the doctor, but so often we seem to fail – leaving it to everyone else. In hospital it usually rests between the houseman and the ward sister and they may receive a more or less definite lead from the consultant. The ward sister often knows the patient and his needs best but feels it is not her job; the houseman is inexperienced and often perplexed by the whole situation, and perhaps it is the nurse doing the blanket bath who gets the direct question. It is certainly not her responsibility and she must pass the question on to someone more senior. Even so she may be nearest to the patient in his distress and best able not only to help him as he faces it, but also the others as they try to understand him.'

Often the hospital chaplain may be the one with whom the patient wants to talk. Dying patients are often depressed, resentful, or angry but this may not be apparent unless they are given the opportunity to talk. Those who are disturbed in this way may be helped by a psychiatrist, always in full consultation with those in whose care the patient is being treated.

What should be said?

There is no simple answer to this question. It depends on the patient's personality and beliefs. Whatever is said must be said gently, without abrupt destruction of any lingering hope that he may still have. Some may be able to face the outcome with cheerful courage or resignation. They may simply wish to make arrangements for their family. Most will require comfort and reassurance. They usually fear the distress of dying rather than death. This fear is often unwarranted and complete reassurance can be given that pain or distress will be relieved. If pain is inevitable, the patient should know that doctors and nurses will ensure that every thing possible will be done to give relief. He will be much encouraged to know that any complaints will be meticulously attended to and that he will not be left to suffer alone and unrelieved. It is most important that the whole clinical team – nurses, doctors, social workers, chaplain, and psychiatrist – should keep each other informed about what has been asked and what has been said.

Cramond (1970) emphasizes how little is at present done to train medical students and nurses in communicating with the dying. He advocates training courses, led by a psychiatrist, for doctors, nurses, social workers, and ministers of religion. Regular meetings could be held in medical schools for all those involved with dying patients to discuss their problems. If this were done, many of our patients who now die in mental distress would receive the comfort that they need and which we, in our turn, may also one day need ourselves.

Dr Wilson also considers the problems of communicating a bad prognosis long before death or serious disability is imminent. If a grave outcome is inevitable but relatively remote in time, it seems to me wrong to extinguish hope. After all, the bad prognosis may be wrong. I try, as Meyer (1969) has suggested, to give the most optimistic prognosis that is consistent with the facts while facing up to the real element of risk. I entirely agree with Wilson's plea, which is supported by Cramond (1970) and Robinson (1973), for frankness with the family, not only about the outcome but also about any ordeal of pain or of disagreeable treatment which the patient may have to undergo and needs to be prepared for. He may be found to have exaggerated fears. It is also important that all who will be concerned with the patient's care in hospital or at home should ensure against contradictory statements which may sow the seeds of distrust.

There must be few doctors who have not been inspired by being privileged to witness the serene courage with which many of their patients face up to and win victory over disablement and death. They can only do this if they are helped to face the truth.

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