



From the editor • Van die redakteur

We're starting 1988 with the "New Science"¹ and a very moving look at cancer and dying². The anomalies of the past and present are our springboard to the future. We are therefore grateful to Joseph Levenstein, Andrea Judge and Mossie Silbert³ for the manner in which they point the way.

Along with society we have done much to banish death from living, to cause untold misery. Ian McWhinney who recently retired from the first Family Medicine chair in Canada, once said, "I sometimes think that care of the dying is the best indicator we have of the state of the medical art, because it reveals what medicine can do when all the technology has failed"⁴.

He has been succeeded at the University of Western Ontario by Dr Brian K Hennen, head of Dalhousie University's department of Family Medicine. Ian is now doing duty as Medical Director of the Palliative Care Unit at Parkwood Hospital in London, Ontario and is the 'Helen Young Professor of Palliative Care' at the University of Western Ontario.

He has led our thoughts into the future for many years through many landmark articles^{5, 6, 7}. We wish him well in his new career and look forward to the fruits of his perceptive mind. I am convinced that more than most, cancer (along with AIDS) is going to force mankind and

medicine to start thinking and living in a complex world rather than the oversimplified one of Newton and Descartes. Both these conditions threaten us with death. Cancer research and therapy has swallowed up astronomical amounts of money and solutions keep eluding us. My guess is that the same will hold true for AIDS if we continue to think and work in inadequate and outmoded terms.

May 1988 see us develop further, beyond the presuppositions of the last century that still holds medicine in their grip. Perhaps death may again become part of living in the years to come.

Sam Feheren

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Guest Editorial

On Telling, Curing and Healing

A sub-leader in the *South African Medical Journal*, titled "Reluctance to break bad news"¹, describes two case histories in which the diagnosis of malignant disease was missed by primary care doctors, in spite of the presence of critical symptoms over a lengthy period. These cases, in fact, reflect *failure*, rather than *reluctance* to break bad news - a serious indictment of our professional responsibilities, particularly so if we expect lay people to recognise these very same symptoms.

Early recognition of cancer is a major responsibility for the general practitioner. Difficulties and delays in diagnosis may indeed arise, in view of the host of undifferentiated manifestations of illness which present to him. However, a high index of suspicion must constantly prevail. This has become all the more crucial in view of significant improve-

ment in the prognosis of many malignant diseases. Vast advances have been made in the treatment of various cancers. The availability of anti-cancer drugs and the participation of South African clinicians in international cooperative controlled trials have resulted in the development of curative treatment for diseases such as lymphatic leukaemia in children, Hodgkin's disease and other malignant lymphomas.² Cures have likewise been obtained in malignant ovarian and testicular tumours.

Doctors in whom the patient invests his trust must also take the responsibility, albeit an onerous one, of breaking the news to the patient and his family. He has an obligation to do so in terms of an ethical commitment to disclose the truth. Reluctance or unnecessary delays in doing so, leaves the patient in a state of uncertainty, mistrust and fear.

Truthful information is frequently with-held on the assumption that this will spare the patient anxiety and concern. Psychologists, on the other hand argue that such an approach reflects projection of the doctor's own anxiety, that he will not be able to cope with the patient's emotional responses. In withholding truthful information, doctors adopt a paternalistic approach imposing on the patient what the doctor believes the patient ought to know. Not only is this affront to the autonomy and dignity of the patient, but it is also in conflict with a moral and ethical obligation to tell the truth so as to enable the patient to share in taking as much responsibility as possible³ for his own life and destiny, as well as to attend to matters of a more temporal nature which he regards as important.

The cold clinical truth, and the way it is disclosed may, however, inflict anxiety and other emotional trauma. Much of this can be obviated by skilful and empathic communication on the part of the doctor. Amongst these particular skills is awareness of the patient's coping mechanisms and adjustive reactions eg denial, anger, anxiety, depression, and an ability of the doctor to tune in and respond to these.⁴ This can significantly facilitate the breaking of bad news as well as diminish its traumatic effects.

In most instances, all information, (or the whole truth,) need not be disclosed at the initial interview. It is, in fact, ill-advised to do so: the patient tends to block out detailed information because of anxiety and denial. He will be more receptive to assimilate such information with the passage of time as he mobilises less radical defences and he can cope more easily. Moreover this approach demonstrates compassion, and consolidates the doctor-patient relationship.

Realistic hope given to the patient and his family, particularly so in this day and age in view of improved prognoses, provides the situation with some meaning from which the patient may gain strength to persevere in the face of fear.⁵ It enables the patient and his family to mobilise their strengths and resources: denial mechanisms are diffused, and positive attitudes are mobilised. Such attitudes can significantly influence the course of the illness - if not the illness itself, as some research workers would suggest.

The role of attitudes, psychological factors and stress have been postulated as factors influencing the course of a malignant disease, as well as the etiology of certain cancers or their recurrences. This remains controversial amongst clinicians in spite of the publication of both anecdotal evidence as well as research studies and clinical trials. As far back as 1870 Sir James Paget⁶ observed that "deep anxiety, deferred hope and disappointment are quickly followed by the growth and increase of cancer", Laurence Le Shan,⁷ WA Green⁸ and S Greer⁹ have highlighted the significance of losses

in the patient's life as factors in the etiology of certain cancers. This may be viewed with scepticism by many clinicians who take an unequivocal scientific and reductionist approach to the etiology of illness.

Where there is consensus, however, or where there *should* be consensus, is that positive attitudes of mind, psychological support and counselling can *significantly* influence the course of the illness. Carl and Stephanie Simonton¹⁰ have pioneered such approaches supplementing the conventional management by surgery, chemotherapy and radiotherapy: "mind-body-spirit" dimensions are incorporated in their holistic management of cancer. This philosophy is enjoying increasingly more universal appeal. Patients, particularly those in whom the illness is no longer contained, perceive that such holistic approaches provide for them hope and resources, in keeping with individual beliefs, philosophies and attitudes to life and death. Doctors, deeply committed to the prescribed role of *curing*, cannot possibly meet individual physical, psychological and spiritual needs of all patients. We should recognise this, and not summarily reject the patient's need, if feasible and realistic, to explore supplementary sources of help merely because these do not comply with the conventional medical model.

Involvement of the family doctor in all dimensions of cancer management reinforces and fulfils a commitment to total, continuing and personal care, and contributes to a concept of *healing* over and above the prescribed role of *curing*.

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