

- racemase defect: another cause of methylmalonic aciduria. *Pediatr Res* 6:875-879, 1972
12. Liu YK, Sullivan LW: An improved radioisotope dilution assay for serum vitamin B<sub>12</sub> using hemoglobin-coated charcoal. *Blood* 39:426-432, 1972
  13. Giorgio AJ, Malloy E, Black T: A clinical laboratory GLC method for urine methylmalonic acid. *Anal Lett* 5:13-20, 1972
  14. Krafczyk VF, Helger R, Lang H: Simplified thin layer chromatography screening test for detection of important hyperaminoacidemias. *Clin Chim Acta* 31:489-491, 1971
  15. Moore WEC: Relationships of metabolic products to taxonomy of anaerobic bacteria. *Int J Syst Bacteriol* 20:535-538, 1970
  16. Frenkel EP, Kitchens RL: A simplified and rapid quantitative assay for propionic and methylmalonic acids in urine. *J Lab Clin Med* 85:487-496, 1975
  17. Whitaker TR, Giorgio AJ: A direct radioassay of methylmalonyl-Coenzyme A mutase using enzymatically synthesized DL-3-<sup>14</sup>C methylmalonyl-CoA. *Anal Biochem* 52:522-532, 1973
  18. Contreras E, Giorgio AJ: Leukocyte methylmalonyl-CoA mutase. I. Vitamin B<sub>12</sub> deficiency. *Am J Clin Nutr* 25:695-702, 1972
  19. Ueda M, Taketa K: Effect of vitamin B<sub>12</sub> derivatives on urinary excretion of methylmalonic acid in liver diseases. *Acta Med Okayama* 24:365-372, 1970
  20. Vivacqua RJ, Myerson RM, Prescott DJ, et al: Abnormal propionic-methylmalonic-succinic acid metabolism in vitamin B<sub>12</sub> deficiency and its possible relationship to the neurologic syndrome of pernicious anemia. *Am J Med Sci* 251:507-515, 1966
  21. Brozović M, Hoffbrand AV, Dimitriadou A, et al: The excretion of methylmalonic acid and succinic acid in vitamin B<sub>12</sub> and folate deficiency. *Br J Haematol* 13:1021-1032, 1967
  22. Tan AWH, Smith CM, Aogaichi T, et al: Inhibition of D(-)-3-hydroxybutyrate dehydrogenase by malonate analogues. *Arch Biochem Biophys* 166:164-173, 1975
  23. Ampola MG, Mahoney MJ, Nakamura E, et al: Prenatal therapy of a patient with vitamin-B<sub>12</sub>-responsive methylmalonic acidemia. *N Engl J Med* 293:313-317, 1975

## SPECIAL ARTICLE

### ANNUAL DISCOURSE — ON CARING FOR THE PATIENT WITH CANCER

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AN Annual Oration or Discourse has been delivered by distinguished members of the Massachusetts Medical Society in almost uninterrupted sequence since the year 1804. For the 195th Anniversary Meeting, I am the 166th Orator, and the second to be selected from my home town of Northampton, the first being Joseph Henshaw Flint, who spoke "On the Prophylactic Management of Infants and Early Childhood" in 1826. Under these circumstances, I am impelled not only to express my heartfelt gratitude to the membership for the honor of delivering this Oration, but also to acknowledge my debt to the many members of this Society who taught me the Art as well as the Science of Medicine. To mention just a few, in surgery I think of Harvey Cushing, Dan Jones, David Cheever, John Homans, Arthur Allen, and Elliott Cutler; in medicine there were Uncle Henry Christian, Sam Levine, Howard Means, Joe Aub, Fuller Albright, Chester Jones, Walter Bauer, and Soma Weiss. One could not omit that incomparable radiopathology pair of Merrill Sosman and S. Burt Wolbach. I could extend the list indefinitely, including many closer to or of my own generation like Bill Castle, Leland McKittrick, Max Finland, Grantley Taylor, Herrman Blumgart, and Gene Eppinger. No student will ever forget those unique teachers, Henry Jackson, Tom Lanman, Charlie Lund, Connie Weselhoef and Wyman Richardson.

I have paused to pay this tribute because these men and many other members of the Society in all three of

the medical schools taught the principles of medical care that are the essence of my presentation today. Francis Peabody's dictum that "the secret of the care of the patient is in caring for the patient" permeated our student days. We learned that the practice of medicine is cold and abrasive unless tempered by love. By love I mean "caritas," that love which binds together men of goodwill of all races and religions. Typified by the story of the Good Samaritan, it is the manna and the leaven of the relations between the patient and the doctor.

Let me now try to illustrate this ancient truth by talking about the patient with cancer. I will not ask the indulgence of the vast majority among you who may feel that I am elucidating the obvious. The fact is that we must talk openly and frequently about these matters because the misinterpreted actions of a few doctors are magnified in the media so as to give the impression that most doctors are unaware of the vital importance of these principles of care, from early or late diagnosis through treatment, to arrest or recurrence, with its concomitant suffering and death. Moreover, we are faced with a grievous misunderstanding of the terminal care of patients with cancer or, for that matter, any other fatal disease. On the one hand, there are misguided cries for euthanasia, and on the other, threatened suits for passive murder or neglect.

Let me begin with a brief account of some personal experiences. I started out with the understanding that cancer was a progressive disease, arising in a single focus, growing steadily at a rate fixed for that particular cancer, reaching a certain size, then metastasizing to the regional lymph nodes, and finally spreading throughout the body. The solution was simple. Early diagnosis, followed by radical surgical excision guaranteed a cure. When cure was not possible, it was

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the fault of the patient or his physician, because of the delay in making the diagnosis. The worst feature of this view was the accepted role of the surgeon. He was available for "cure" only. Once the disease had spread beyond the confines of local control, his contribution was ended. I cannot tell you how many times I heard and even myself said, "I am sorry, I can do nothing more for you." It was an easy out for the surgeon. Either he won the ballgame or he wasn't supposed to play at all.

In early 1946, just having returned from four years overseas in World War II, I was invited to review the records of a group of patients in the Home of the Holy Ghost in Cambridge, a nursing home devoted to the care of the incurable patient, particularly those with cancer. In fact, if I remember correctly, when the patient entered the institution, his worldly possessions were given to the nuns, for which they promised complete care for life. Because of insufficient medical supervision, the Home was in danger of losing its accreditation so several young physicians and surgeons, including Dr. William Moloney and me, most of us embryo academicians just back from the war, were invited by Cardinal Cushing to review the records and help bring the details of each patient's care to an acceptable standard.

It was an extraordinary experience. The "Home of the Holy Ghost" was not only a cheerful but, in fact, a very happy place. The devoted nuns provided superb nursing care, and the patients for the most part had acquired that equanimity which is a natural part of approaching death. Our review quickly disclosed that from a strictly medical point of view, the records were quite out of date. Most astonishingly, many patients thought to have been terminal months or years earlier were still living, some of them apparently quite well.

Among the cases that I reviewed was that of a patient with an unquestionable, histologically established diagnosis of cancer of the cervix, who had been discharged 12 years earlier from a distinguished Harvard University hospital. The cancer had failed to respond to surgical and radiation therapy so that at the time of discharge, the patient was moribund, with profuse bloody vaginal discharge, marked anemia and cachexia. Indeed, a sympathetic house officer had entered a note in the records questioning the desirability of transfer because the patient would hardly survive more than a day or two longer.

It was obvious that there was no mistake about the patient, her illness, nor the prognosis. She had languished close to death for many days and weeks, and then had undergone a slow, progressive, and apparently complete recovery. At the time I examined her, she was in excellent health. There was evidence of heavy irradiation of the pelvis, with marked contraction of the vagina, but no signs of cancer. The patient was working full time as a happy and cheerful nurse's aide. Since she had no close relatives, the Home of the

Holy Ghost had become her home, and she was determined that she would enjoy it until that happy day when, as had been predicted, her life would end with terminal cancer.

That experience and a number of similar cases in my personal practice made it obvious to me over 25 years ago that one cannot predict the precise course or outcome of cancer.<sup>1,2</sup> The old adage "he will be dead in six months" or "I will give him a year to live" is an unforgivable statement for a physician to make: unforgivable because there are no valid grounds to make so rigid a prognosis. It may be three months, six months, six years or longer. One can never tell. This uncertainty about the future introduces a ray of hope, however small, for both patient and family.

Do not misunderstand me. I am not promoting false optimism. I am merely emphasizing that the course and ultimate outcome can only be determined by day-to-day observation. No matter how grim the situation, there is always room for hope. Indeed, the benefits of alleged cancer cures like krebiozen in the past and laetrile in the present are due largely to the failure of our profession to emphasize to patient and family how variable the course of disseminated cancer may be.

Let me now detail certain specifics regarding care. I have nothing new for those who are experienced, but the subject deserves constant repetition for the neophyte and for those who do not deal frequently with this problem. Indeed, much of the current misunderstanding with the public and the press stems from failure to emphasize these matters. It takes one hundred explanations and documentations of what is good care to put out the fire of criticism set off by the story of one mishandled and unhappy patient.

The first meeting of physician or surgeon with the patient is the most propitious. In a case of cancer, the situation is more critical because the patient may have been studied previously and a tentative diagnosis made. For this reason, it is essential that sympathetic rapport be established by the consultant. The patient is vulnerable. He expects the worst. Frightened and uneasy, he needs more than anything to be recognized as a human being, not as a disease. He wants the compassion and understanding that only his doctor can provide. A casual remark, a hurried examination or a brusque manner may affect the patient throughout his entire illness. A quite unintended misunderstanding may set the stage for an unjustified malpractice suit months or years later. In achieving rapport the manner of the physician influences the patient's feelings more than the quality of the care. This fact, of course, accounts for the success of the quack.

No doctor can tell another how to conduct this stage of patient care. It is a very personal matter, varying from doctor to doctor and patient to patient, but it is essential for the doctor to listen, to understand and

to explain. Sometimes, he can do so in a few minutes; at other times, it takes much longer. If there is not sufficient time, the physician must find it at the earliest possible moment, perhaps putting off a complete explanation on the grounds that more information will be available later. In any event, at the end of this first meeting the patient must have a sense of trust and hope.

Sooner or later the time comes when the patient must be told the diagnosis and some type of prognosis must be made. There are two points to stress. The first is that the patient, his wife and selected members of the family must be involved in the discussions. Secondly, as I have mentioned earlier, no rigid prognosis should be made. As far as the first point is concerned, if the patient is told one thing and his spouse or members of the family something different, sooner or later someone will sense that the truth is being withheld. The greatest anxiety, confusion and misunderstanding have developed from this outworn and ill advised approach. As an example, I recall an incident in which a man, having been told that he had a fatal form of cancer, and not long to live, asked his doctor to withhold the information from his wife. For many years the couple had dreamed of a trip around the world by sea. Quite naturally, the patient proposed that they make immediate plans to depart. His wife, however, not knowing the circumstances, wanted to take a few months longer to put things in order and relish the details of planning the adventure. The patient, of course, with death supposedly hanging over him, insisted that they go as soon as possible. It turned out to be a miserable trip for both of them. The wife berated her husband every time something went wrong because of their precipitous departure. The husband thought of himself as a silent martyr trying to be kind to his spouse. When they returned home, he finally told his wife why he had insisted upon making the trip so precipitously. Her response is most revealing, "If you had only told me that we might have only a year together, we would have had a superbly happy time because we both knew and understood the situation!" Ironically, as so often happens, he remained relatively well for some years!

The second point concerns the matter of prognosis. In favorable cases it is easy to be optimistic, but even in the worst situations, a generally reassuring attitude should be taken. The more important the patient and the greater his responsibilities, the more determined he is to find out exactly how long he has to live. I have repeatedly had prominent executives complain that I was trying to mislead them when I said I really did not know. A useful ploy at times is to ask the patient how long he wants to live. It is surprising how few of us really have a firm conviction on this point. In fact, with the present state of the world, the economy, the weather, the Middle East crisis, and things in general, many of us wonder if it is worth living at all!

Usually, an older patient will express a hope to live long enough to enjoy some specific event, a grandchild's graduation from college, the marriage of a son or a daughter, or a long planned family reunion, usually no more than a year away. One thing I have learned is that if a patient is told he is going to die in six months and doesn't, he never forgives the doctor. If one is overly optimistic, however, the patient is understanding, so that under such circumstances, the doctor should always be reassuring. In fact, in many cases I have reassured patients from one event to another, going on for months or years. Instead of feeling the Sword of Damocles over their heads, they carry on bravely and confidently from day to day.

Sometimes patients will demand a specific prognosis on the grounds that critical financial adjustments must be made in their affairs. Under these circumstances, I advise emergency legal advice before leaving the office, because the risk of dying in a car accident on the way home far exceeds the risk of dying of cancer in the next year or so!

The best thing is to suggest odds and percentages, leaving ample room for shorter or longer periods of complete well-being. This approach leaves the patient with a distinct ray of hope that he may master his disease through treatment or natural means. It also assures that an unexpected arrest or regression will fit into the patient's concept of his illness. The stage has not been set for a quack to take credit for the natural course of events. My own experience convinces me that in 30 or 40 per cent of the cases, some degree of subjective or objective arrest or remission occurs. Indeed, this spontaneous improvement is why controlled trials are the best way to evaluate new methods of treatment.

The details of treatment are not within the scope of this lecture, but I must emphasize that any physician or surgeon who accepts responsibility for the care of a patient with cancer must have a sound background and understanding of the pathophysiology of this variable and unpredictable disease. The extent and details of therapy, the management of recurrences, and, indeed, the total care of the patient depend on the physician's knowledge of the vagaries, not only of that particular cancer, but of that cancer as it presents in this particular patient. Because as yet there are no certain methods of cure, there can be no rigid routines. If therapy is not uniquely adjusted to each patient, varying degrees of inadequate, ill advised or inappropriate treatment may follow.

One who deals with the patient with cancer must be aware of new developments. We are in a period of rapid change. Every day some new approach is hailed in the lay press as revolutionary despite clearly expressed reservations on the part of the investigators. The physician who deals with the patient with cancer must be aware of these developments. He should know, for example, that a controlled clinical trial that

delays recurrence of cancer in a high-risk population for a few months or a year or so at the cost to the patient of skin rashes, diarrhea, fatigue, weakness and loss of hair is not to be adopted as adjunctive treatment for all patients with the same kind of cancer. On the other hand, he should know that the combination of irradiation, surgical excision and chemotherapy holds great promise and already is the established treatment for a number of bone and soft-tissue sarcomas. In fact, chemotherapy appears to be on the edge of remarkable progress in the management of several hitherto quite uncontrollable tumors, and very recently it appears that heat applied to tumors by radiofrequency may produce remarkable regression.<sup>3</sup> BCG transfer factor and levamisole may all have their place, but precisely how to use them is still an area for careful evaluation. In fact, no innovative manipulation is without potential hazard and, consequently, should be employed only by experts in the field.

We come now to the sad fact that the vast majority of cancers are rarely, if ever, permanently cured. So-ma Weiss, whom I mentioned earlier, used to say, "In Vienna, they taught that if you once had cancer, you would die of cancer if you lived long enough." So-ma would have been very interested in Mueller's study of over 1500 unselected cases of breast cancer from the Canadian Cancer Registry showing by the actuarial method that the rate of dying is constant at five, 10 and 15 years.<sup>4</sup> Similar data have been reported by Brinkley and Haybittle.<sup>5</sup> It is clear that there is no such thing as a "five-year cure." I have myself seen recurrences over 30 years after apparently successful therapy. Of course, these late recurrences are superb examples of natural resistance with control of the disease through immunologic or other mechanisms.

What is the role of the surgeon or oncologist in the dark picture of what seems to be relentlessly advancing cancer? I have already stressed the tragic consequences if either of them withdraws from the case on the grounds that "nothing more can be done." Even in the apparently most hopeless situations, arrest or remission may occur so that hope must never be completely withdrawn. Furthermore, because the surgeon or oncologist usually has been the bright hope of successful therapy, withdrawal implies disaster. Finally, and most important of all, as I shall explain more fully later, the patient is not afraid of death, but he is terribly afraid of being abandoned by his physician in the face of death. There is solid support for this view: the excellent book *On Death and Dying*, by Kübler-Ross<sup>6</sup>; Jocelyn Evans's moving account of the death of her husband, *Living with a Man Who Is Dying*,<sup>7</sup> a splendid study of patients dying of cancer reported many years ago by Dr. Ruth Abrams,<sup>8</sup> and the recent reports of the work of St. Christopher's Hospice in London.<sup>9</sup>

Jocelyn Evans presents a sad picture of the care of

her husband, who is found to have inoperable cancer of the pancreas. The surgeon is competent but coldly efficient. Even when he says the right things, it is without sympathy and understanding. After the patient is sent home, the family physician fails to visit him on the grounds that she has nothing to offer. On one occasion when the patient is greatly distraught, with terrible anxiety and pain, his wife in desperation in the middle of the night calls upon a young resident who lives in the same apartment but has had no professional involvement with the case. His prompt response, quiet questions, reassuring recommendations and gentle physical examination bring the patient dramatic relief. Indeed, he remarks to his wife, "that is the first time that a doctor has touched me since I left the hospital."

Terminal care should begin in the hospital, but all too often the doctor followed by his team goes from bed to bed through the ward, until the room of the supposedly dying patient is reached. Then follows a whispered exchange with the nurse. The patient seems to be asleep, better not to disturb him, so with relief and a suppressed sense of guilt, the procession glides by. This is a grievous mistake. The one patient on the service who wants most to be seen, examined and talked to is the patient who is or may be dying. One need not hold lengthy discussions over such a patient, the entire retinue should not crowd into the room, but a sympathetic visit on the part of the responsible doctor can be more beneficial than an extra dose of narcotics. One should ask the patient about his pain, listen to his chest, do a gentle examination and then make recommendations for changes in management. Attention to the little details, such as food, drink, bowels, position in bed and air in the room, brings big emotional dividends. Above all, touch the patient, shake hands, take the pulse and gently palpate the areas of pain.

The same situation continues once the patient has been sent home or to a nursing home. A competent physician who is familiar with the case and in whom the patient has confidence must continue to see him at regular intervals. If at all possible, the patient should be seen from time to time by the surgeon or oncologist who undertook the initial definitive care. I have found it exceptionally valuable to bring the patient back to the hospital for re-examination and reappraisal. He will look forward for days to the time of the next visit with his specialist, surgeon or physician. Even if no objective improvement follows, subjective benefit is immeasurable. Moreover, transient remissions or stabilizations in the natural course of the disease often, by chance, follow such a return visit. The beneficial effects, subjective or objective, may last for days, weeks or even months.

The value of a visit to the home of the patient on the part of the surgeon is unbelievable. At one time I was able to see terminal patients in their homes, and I can testify that the reward to family, patient, referring

physician and surgeon is one that cannot be put into words. On these occasions, everyone knows the facts. No one is being deceived, and yet there is a curious ray of hope that in some odd way the situation may improve. Intolerable pain may often be relieved for hours or days without any change or increase in medication. I do not wish to stress precise details except to emphasize that aspirin, its substitutes, phenobarbital, codeine, sometimes a little cortisone, and often alcohol may be employed for very long periods before it is wise to use morphine or hydromorphone (Dilaudid). In my own experience, the modern tranquilizers and meperidine (Demerol) are the least effective in most cases. Rotation of medications in small doses and in combination often seems to postpone the need to increase dosage. Sometimes, Schlesinger's solution proves to be a mainstay. Heroin, if it could be obtained, has the great advantage of relieving pain without clouding the mind.

As the end approaches, there is nothing so important as death with dignity, but this choice is not euthanasia. Euthanasia is described in the dictionary as "mercy killing," but it would be more realistic to call it "therapeutic murder." It is not death with dignity, and it is contrary to and offends not only the Judeo-Christian ethic but that of many Eastern and most primitive religions. Euthanasia is based on Hegelian philosophy. What is useful is right. If one can destroy the dying patient to relieve his pain, one can put him to death like a sick animal. He can be killed just because he is a burden to his family and society. This philosophy promoted by Hitler and the Nazis set the stage for the mass executions in Germany in World War II. If what is useful is good, there is no end to what one can do. If you have any doubt about this, I urge you to return once again to Leo Alexander's classic paper on "Medical Science under Dictatorship," which appeared in the *New England Journal of Medicine* in 1949.<sup>10</sup>

Recently, Arthur Dyck, professor of population ethics at the Harvard School of Public Health and also a member of the faculty of the Harvard Divinity School, reached similar conclusions but saw the issue less clearly in the current shadows of a world that has lost so many old-fashioned values. Dyck contrasts two contending policies regarding the value of life: one the "quality-of-life issue" and the other the "equality-of-life issue." In the end he supports the latter view by bringing us back to the lesson of the Good Samaritan. We must administer to the care of the maimed, the dying, the bleeding and the incompetent. His final words are, "the moral question for us is not whether the suffering and the dying are persons, but whether we are the kind of persons who will care for them without doubting their worth."<sup>11</sup>

Returning to euthanasia, I must emphasize again that in Nazi Germany, the opening wedge for mass genocide was the presentation to the public of films showing how gently and beautifully life could be taken

from a patient because he was crippled, incompetent or suffering. This was the first step. The next was the elimination of the life of anyone who gave someone else a sense of being pained, uncomfortable or burdened. Justified by Hegelian philosophy, mercy killing of the sick and incompetent by deliberate and positive actions paved the way to the gas chamber for millions of innocent men, women and children.

We cannot destroy life. We cannot regard the hydrocephalic child as a "non-person" and accept the responsibility for disposing of it like a sick animal. If there are those in society who think this step would be good, let them work for a totalitarian form of government where beginning with the infirm and incompetent and ending with the intellectually dissident, "non-persons" are disposed of day and night by those in power. History clearly shows the frighteningly short steps from "the living will" to "death control," to "thought control" and finally to the systematic elimination of all but those selected for slavery or to make up the master race. We physicians must take care that support of an innocent but quite unnecessary "living will" does not pave the way for us to be the executioners while the decisions for death are made by a panel of "objective experts" or by Big Brother himself. The year 1984 is not far away!

The care of the hopelessly ill or mentally incompetent "non-person" is a trying but noble burden that society and the health professions — especially the nursing profession — God bless them! — have assumed and must continue to bear. Fortunately, for the patient with cancer, attentive appropriate care with adequate medication to control pain, in massive doses if necessary, permits death with dignity.

Although we cannot destroy life, we are never obligated to preserve it. The duty of the medical, nursing and allied health professions is to relieve suffering and to promote health and well-being. In the initial emergency life must be saved. Life is saved in the hope that with recovery, the patient may be returned to a state of tolerable well-being and the enjoyment of life. There is no moral responsibility for prolonging life by any specific medical treatment when it is clearly evident that this course only preserves an existence in a state far worse than death. If the duty of the medical profession were to preserve life, we should be developing and using technics whereby the heads of patients could be fitted to appropriate perfusion systems that would maintain the cerebral circulation indefinitely. Everyone could have a family tree hanging from the parlor wall in suitably decorated squawk boxes!

We must understand and realize the very fine but critical line between a positive action that leads to death (euthanasia) and the withholding or withdrawing of forms of therapy that prolong life without benefiting the patient. Finer and harder to

see than the "Thin Red Line of Balaclava," it is of immensely greater importance that it be held for the preservation of morality and life in this small world.

I repeat, there is no need to resuscitate the terminal patient. There is no need to prolong a useless and tragic life by forced feeding or giving antibiotics to frustrate bronchial pneumonia, the traditional friend of the hopelessly ill or the aged. It is inhuman to drag the dying patient to radiation therapy, to transfuse him repeatedly or to give massive toxic and nauseating chemotherapy to relieve one tiny facet of an intolerable existence, thereby dragging it out for a few more agonizing days or weeks. That is the science without the humanity of medicine.

Shakespeare put it very well in *King Lear*. The King, broken and defeated, is dying. There is a call for a physician, but Kent cries, "Vex not his ghost: O, Let him pass! he hates him much that would upon the rack of this tough world stretch him out longer." Let us not be found guilty of stretching out our incurable and dying patients on the rack of this world.

We must not allow the decision to permit death with dignity to be made by a committee or the courts. The responsibility should be borne by one physician, but he must have the confidence and understanding of the patient and the family. Moreover, the same care that governs all critical judgments in medicine must be exercised — namely, consultation with colleagues and, if there is the slightest doubt about the potential efficacy of treatment, transfer of the patient to a center specializing in the injury or disease in question. Whenever there is reasonable doubt about restoring the patient to health or tolerable existence, treatment must be continued.

Unfortunately, the ability of the medical profession to preserve life by artificial means has attracted the attention not only of the public but of the legal profession. The shadow of malpractice and misinterpretation of the law have created an atmosphere of confusion and misunderstanding. The entire issue was highlighted by the Karen Ann Quinlan case. The original decision of the judge not to interfere with the medical profession is sound, because if the courts become regularly involved in the details of the care of the patient, we will pass into a phase of medical care more intolerable than anything Aldous Huxley foresaw in *Brave New World*. Quite apart from the dangers of euthanasia I deplore the concept of "the living will" or of requiring the family to sign a form approving the right of the physician to permit death with dignity. I know of no ethics in any religion that requires prolongation of life for the sole purpose of maintaining it. It will be sad indeed if in those precious, close, intimate, and final moments the doctor must have a will or any legal document to do what has been done and should be done in these circumstances.

Let us heed the warning of Richard A. McCormick, S.J., in a recent editorial in JAMA:

...The real moral issue in the Quinlan case is not merely a narrowly casuistic one about the limits of our duty to sustain life. That problem is present, of course, but the abiding issue is deeper and broader than that. It is the very moral matrix of the healing profession. That matrix roots in the conviction that decision-making within health care, if it is to remain truly human and an expression of the cardinal rule of the physician, *primum non nocere*, must be controlled primarily within the patient-doctor-family relationship, and these decisions must be tailor-made to individual cases and circumstances. If technology and law were largely to usurp these prerogatives — as they threaten to do as a result of the Quinlan case — we would all be worse off; impersonal considerations would replace personal ones and preprogram our treatment. That is always the root of oppression and depersonalization, in medicine as well as in economics, government, and the church;...<sup>12</sup>

Proper care of the dying patient does not end with the withdrawal of extraordinary forms of treatment. Skilled nursing care, appropriate relief of pain by narcotics and sometimes small amounts of intravenous fluid to keep mucous membranes moist and clean do not prolong life, but they permit death with comfort and dignity. This is simply proper, tender, loving, terminal care. It is totally different from either active destruction of the patient or the use of positive means to drag out life for a few more dreadful hours, days or weeks.

Liegner's description of the work of St. Christopher's Hospice is pertinent:

St. Christopher's Hospice teaches us that total care does not end when acute and chronic care are completed. The physician's 'contract' with the patient extends to the management of his dying and his death and extends even beyond, to his surviving family. The Hospice teaches a new attitude towards acceptance of dying and death as a part of being born and part of the struggle of life.<sup>9</sup>

Actually, there is nothing new in the concept that death is a natural part of life. Alfred Worcester, another distinguished member of the Society, dealt with the problems most effectively over 40 years ago in his little book, *The Care of the Aged, the Dying and the Dead*.<sup>13</sup>

Recently, Cicely Saunders, medical director of St. Christopher's Hospice, has written, "the care of dying patients or terminal care, as it has come to be called, is no new thing. Few of us do more than learn from other people and St. Christopher's has joined St. Joseph's Hospice, the Hostel of God, St. Luke's Hospital, the Marie Curie Foundation and others in trying to fill what has been a gap in the general medical services."<sup>14</sup>

I learned a great deal from my visits to the Home of the Holy Ghost many years ago, and I am sure that many among you have had similar experiences. The difficulty is that we have not talked and taught about it as much as we should.

The unwarranted efforts of some doctors to prolong life by any means as long as possible may be caused by an abnormal fear of death. Camus and the existen-

tialists saw death as the most awful thing in life, but most religions have regarded it as the beginning of a new or different life. Whether death is eternal sleep or a new life makes little difference. In fact, Shakespeare had Hamlet see eternal sleep as the better choice:

...by a sleep to say we end  
The heart-ache and the thousand natural shocks  
That flesh is heir to, 'tis a consummation  
Devoutly to be wish'd. To die, to sleep;  
To sleep: perchance to dream: ay, there's the rub;  
For in that sleep of death what dreams may come  
When we have shuffled off this mortal coil,  
Must give us pause.

The music, literature and history of the world demonstrate the almost inexhaustible capacity of man to endure adversity, suffering and death. Tragedy inspires us, whether it is Roland before the dark tower, Elizabeth Barrett at 1 Wimpole Street, Anne Frank in the attic, or Solzhenitsyn on the Archipelago.

Nelson at Trafalgar knew he was dying. As the French ships were striking their colors he was informed of the victory. This man, who had already given an eye and an arm for his country, did not beg his surgeon to save his life. He was relieved that England was safe. Stonewall Jackson, as he was bleeding from a fatal wound asked "to be taken across the river and into the trees." I have always supposed that he was merely asking to die on the Confederate side of the river! I have had many personal experiences of family and friends in which the dying person has said, "Don't be sad. It is about time and I am ready for it."

Primitive people have had a more realistic view of death. Nordhoff and Hall described how aged Tahitian couples selected the time of their death, arranged for a large family gathering to celebrate the event and then withdrew quietly to a separate hut, to be found dead in the morning. As far as Nordhoff and Hall could determine, no drugs were used.

The beauty and the truth are to be found in poetry. From the heart of Keats, a physician who suffered from tuberculosis when it was a commonly fatal disease, came:

Darkling I listen; and for many a time  
I have been half in love with easeful Death  
Call'd him soft names in many a mused rhyme  
To take into the air my quiet breath;  
Now more than ever seems it rich to die  
To cease upon the midnight with no pain  
While thou art pouring forth thy soul abroad  
In such an ecstasy!

One of Harvard's greatest teachers and scientists, Hans Zinsser, in whose laboratory the stage was set for John Enders to identify the poliomyelitis virus,

knew he had a fatal form of cancer. He saw it this way:

Now is death merciful. He calls me hence  
Gently, with friendly soothing of my fears  
Of ugly age and feeble impotence  
And cruel disintegration of slow years.  
Nor does he leap upon me unaware  
Like some wild beast that hungers for its prey,  
But gives me kindly warning to prepare:  
Before I go, to kiss the tears away.  
How sweet the summer! And the autumn shone  
Late warmth within our hearts as in the sky,  
Ripening rich harvests that our love had sown.  
How good that 'ere the winter comes, I die!  
Then, ageless, in your heart I'll come to rest  
Serene and proud, as when you loved me best.

In conclusion, death is as natural as birth. Regardless of religious belief, when the finality of death arrives, the patient acquires a singular equanimity. Under appropriate circumstances, the anxiety and fear of dying are reduced to a minimum. The role of the physician in accomplishing this goal is unbelievable, but instead of being duped by the illusion of euthanasia, we doctors must hail the spirit that permeates the Home of the Holy Ghost, St. Christopher's Hospice, and many other hospitals and institutions throughout the world. All we need to do is stand up and show the public that we understand.

Death holds no fearful threat. Living without life is Hell. Death is natural; it may be just; it is often easeful and merciful; it ought always to be dignified. Who knows, it may be Paradise.

## REFERENCES

1. Dunphy JE: Some observations on the natural behavior of cancer in man. *N Engl J Med* 242:167-172, 1950
2. *Idem*: Changing concepts in the surgery of cancer. *N Engl J Med* 249:17-25, 1953
3. LeVeen HH, Wapnick S, Piccone V, et al: Tumor eradication by radio-frequency therapy. *JAMA* 235:2198-2200, 1976
4. Mueller CB, Jeffries W: Cancer of the breast: its outcome as measured by the rate of dying and causes of death. *Ann Surg* 182:334-341, 1975
5. Brinkley D, Haybittle JL: The curability of breast cancer. *Lancet* 2:95-97, 1975
6. Kübler-Ross E: *On Death and Dying*. New York, Macmillan Publishing Company, 1969
7. Evans J: *Living with a Man Who Is Dying: A personal memoir*. New York, Taplinger Publishing Company, 1971
8. Abrams RD: Social casework with cancer patients. *Soc Casework* 32:425-432, 1951
9. Liegner LM: St. Christopher's Hospice, 1974. *JAMA* 234:1047-1050, 1975
10. Alexander L: Medical science under dictatorship. *N Engl J Med* 241:39-47, 1949
11. Dyck AJ: The value of life: two contending policies. *Harvard Magazine*, January, 1976, pp 30-36
12. McCormick RA: The Karen Ann Quinlan case. *JAMA* 234:1057-1058, 1975
13. Worcester A: *The Care of the Aged, the Dying, and the Dead*. Springfield, Illinois, Charles C Thomas, 1935
14. Saunders C: *The care of the dying patient, The Problem of Euthanasia: Proceedings of a conference held at the Royal College of Physicians*. London, Contact, Limited, 1972, p 12