

*Clinical Topics***The modern hospice and its challenge to medicine**

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There is a major difference between a hospital and a hospice, well illustrated by an extreme example. The Christie Hospital and Holt Radium Institute was opened in Manchester in 1934 as the centre for major radiotherapy for the North-west, catering for a population of 4.5 million. All the necessary and expensive apparatus and staff were concentrated in the one hospital. On being appointed honorary physician in 1938, in addition to access to the radiotherapy and surgical wards I was given four "long-stay" beds for patients with cancer no longer amenable to specific treatments. Soon, however, the demand for beds for patients whose cancer could be treated was such that the four beds had to be reallocated. Very understandable—a question of priorities.

In the hospital we often used a medical shorthand on patients' records. Thus "NMTBD," for the initiated, meant "nothing more to be done." The relevant possible lines of treatment had all been given and had failed. Now anyone who knows the Christie Hospital is deeply impressed not only by its technical expertise but by its atmosphere of hope and warm humanity. With the best will in the world, it could do no more: for the cancer there was "NMTBD."

What happened to these patients? About half of them died at home, attended by their family doctor, their relatives, and the district nurse; and others died in their local hospitals. Usually these are the most humane and reasonable solutions, but in some cases they resulted in great distress and even cruelty to both patients and relatives.

Terminal cancer is not always painful. About half of all patients with cancer have little or no pain, but 40% experience severe pain.^{1 2} It is here, in dealing with the pain and distress of an incurable disease, affecting both patient and family, that the hospices are a great boon. Though there is "no more to be done" for the cancer, much can still be done for the patient—and for his relatives.

In the hospice the centre of interest has shifted from the disease to the patient, from the pathology to the person. This is not to suggest that in our hospitals the disease is more important than the patient. The hospital has a specific purpose—to diagnose and to treat. Hence the concentration of highly trained staff, laboratories, operating theatres, and diagnostic facilities, which are unnecessary in a hospice. The danger is that we doctors become absorbed in and fascinated by our detective-like function in tracking down disease, and in our undoubted skills in selecting the right treatment. And there are so many patients, so much to be done.

Objectives of a hospice

The objectives of the modern hospice are simpler though not easier to attain. It has now a well-recognised teaching function—namely to educate doctors, nurses, clergy, social workers, and others in the care of patients with terminal disease. In relation to its patients a hospice has two main purposes—firstly, to bring relief, and, secondly, to establish an environment in which there is security, peace, and hope.

There is no doubt that a vast amount of suffering in late cancer can be prevented and today is prevented in the hospices. This preventable suffering, seen by the family in the home, and sometimes indeed in hospital wards, has helped to create the universal horror of the diagnosis of cancer, and is a cardinal factor in the pressure to legalise euthanasia. Great advances have been made during the past two decades in relieving pain, advances to which the hospices have made a valuable contribu-

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tion. Relief is given not only by suitable combinations of drugs but by timing their administration to anticipate and prevent the pain, yet without making the patient drowsy. But there is more to analgesia than analgesics. Emotional and psychological factors—dread of recurrence of pain, fear of dying alone, and stresses in the home—are highly important. The care of terminal cancer often demands professional skills of a high order in medicine and nursing, an expert care that is individual to the patient, detailed, sensitive, and time consuming. A hospital ward is, generally speaking, no place for a slowly dying patient. There is too much necessary activity, too much demand on the time and energy of the nursing and medical staff.

The other purpose of a hospice, to create an environment in which its patients may find security, hope, and peace, is a tremendous human challenge. In most hospices considerable success has been achieved, as any who work or visit there will testify. This is the outcome of caring for the patient as a person, and is shown in a multitude of details. For example, the ambulance is met by the matron or her deputy, who welcomes the patient by name; the patient is lifted into a warmed bed, not on to an impersonal metal trolley. Great attention is given to décor—pictures, carpets, curtains, furnishing, colours. The nursing staff is hand picked for personal qualities as well as for nursing calibre. A high staff-patient ratio is essential not only to give nurses time simply to be with patients—"chat time," it has been called—but also because nursing procedures are heavy and exacting, most of the patients being far advanced in their illness. At St Ann's Hospice, Manchester, for example, 87% of patients admitted die ultimately in the hospice, the average duration of their stay being five weeks. Death is thus an almost daily visitor, and is not regarded as defeat for often it comes as a friend. Indeed, many patients lose their fear of dying when they see how peacefully the end comes to some of their companions. But death can sometimes be deferred, for the new skills bring such relief that the patient may return home for a time under a well-thought-out system of continuing care.

You might imagine that such a concentration of terminal illness and death would create an atmosphere of depression and hopelessness. Far from it. Naturally there are great emotional and spiritual stresses, but these are effectively countered by the warmth and openness of the team life that grows up among the whole staff. Indeed, hospices are marked by a cheerfulness, willingness, and mutual helpfulness that is sadly lacking in some of our hospitals.

A challenge to our philosophy

I have discussed the difference in function between the hospital and the modern hospice. Is there also a difference in basic motivation, a difference that constitutes a challenge to us as doctors and especially to those who train us and those who lead us? Those who create and operate a hospice are inspired by their caring for patients as people, by an urge to alleviate physical and mental suffering, and by a wish to bring hope and comfort to the dying and the determination to walk beside them to the very gates of death. Can we honestly say that these are the main motives that inspire the work of most doctors? Undoubtedly they are active in us, as is shown by the widespread interest in and support for the work of the hospices. But would it not be true to say that these motives have powerful rivals, such as the desire for power and the fascination of science?

A doctor is a figure of power. Of this we are well aware, but most of us are probably unconscious of its range and depth. We are natural "father figures," accepting that status graciously and giving it our encouragement, even though recent decades have eroded the role. As the late Lord Platt remarked, "Fifty years

ago patients believed that their doctor knew everything. Nowadays we doctors know so much that we no longer need to pretend that we know everything." Whatever our patients may believe, our actual control over their diseases through diagnosis and treatment has increased enormously. And we enjoy our pedestals, and even expect that our authority should be accepted outside our strictly professional field. A good friend said to me, "You need to stop being the consultant"—and I knew she was not referring to medicine. The extent to which this urge for power motivates us as doctors, even when we are amblyopic about it, is well described by Dr Paul Tournier.³

Science fascinates the human brain, a perpetual irritant to the cortex and a tonic to the hypothalamus. This, along with its immensely practical value, makes it not surprising that the science of medicine dominates the doctor's university curriculum. But there is much more to the practice of medicine than the science of medicine. Physicians are more than veterinary surgeons. In dealing with human health and sickness science has major limitations. One limitation is that science as a whole is concerned with "How?" and not with "Why?", with mechanism but not with meaning. For example, the scientist studies how man evolved, but not why man exists. Our training as doctors gives us such faith in our science that when we reach its limits we usually recoil. We readily answer our patients' questions about the mechanisms of life and death, but we resort to platitudes when they ask us about the meaning of life and death. Death is defeat, an intellectual and emotional embarrassment. Thus the dying, though visited professionally by their doctor in the home, or only too briefly by their consultant in the hospital ward, intuitively sense that they are "written off"—and indeed they often are, even by their relatives: the bereavement of the dying. In the science of medicine death is the end: NMTBD.

The real challenge to medicine raised by the modern hospice is to our basic philosophy as doctors, indeed to our whole concept of the meaning and purpose of human life. *The Concise Oxford Dictionary* defines a hospice as a "house of rest for travellers, especially one kept by a religious order." We are all of us travellers, and those who enter a hospice as patients know that they are nearing the end of the journey. The modern hospice is much more than a nursing home for the dying. It is a "religious and medical foundation." Such is the inspiration that created, among others, St Christopher's Hospice in London, pioneered by Dr Cicely Saunders, and St Ann's Hospice in Manchester, founded by the late Dr William Greer, the then Bishop of Manchester. Their medical aim is to be centres of excellence in the relevant medical and nursing skills, and centres of education for doctors, nurses, clergy, social workers, and others in caring for the dying and their families. Their religious aim is to create an environment in which patients with terminal illness can experience the love of God mediated through the dedicated care of human beings. The criteria for admission as patients are primarily their clinical need and secondarily the family conditions, and have nothing to do with finance or religious beliefs.

Such an environment of skill, caring, hope, and faith enables many, previously tormented and terrified by their disease, to find relief and peace in their last weeks and days. Some find for themselves a faith and hope that takes death in its stride. As one patient said, "It is wonderful to feel safe again."

References

- 1 Turnbull, F, *Proceedings of the Royal Society of Medicine*, 1954, 47, 155.
- 2 Aitken-Swan, J, *Practitioner*, 1959, 183, 64.
- 3 Tournier, Paul, *The Violence Inside*. London, SCM Press, 1978.

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