MEDICAL PRACTICE

Spring Books

Of grasshoppers, figs, and death

L R C AGNEW

I hope this title suggests a strange mixture, because this presentation is a sort of thanatological opera with many different performers, and a leitmotiv of literature and death. The title was culled from one of Sir Thomas Browne's less familiar writings; his *Letter to a Friend* which was published in 1690, eight years after Sir Thomas died. In this short piece Browne describes his visit to the bedside of a young man who was dying of pulmonary tuberculosis. As one commentator has observed, "Here we have no poet and dreamer drudging at the scientist's task, but a sensitive mind alert to the symptoms in the afflicted body before him, yet deeply aware of the mysteries of human existence. As he describes the slow, quiet death of a young man suffering from phthisis . . . the two sides of Browne's mind play alternatively: the physician observes the symptoms while the philosopher reflects on their meaning; his imagination soars to remote possibilities, yet is never quite free from the restrictions of the intellect."[1]

What I liked especially was the wonderfully gentle way Browne broke the bad news of the lad's impending death to the relatives. Here it is, in his own words: "Upon my first visit I was bold to tell them who had not let fall all hopes of his recovery, that in my sad opinion he was not like to behold a grasshopper, much less to pluck another fig."[2]

The right words at the right time

This, then, is my first point—the need for a sensible and sensitive choice of words when dealing with death and dying. No two cases are alike—everyone's needs are different—and we have to be alert for those small subtle signs, often non-verbal, which will indicate the right time to say the right thing to the patient and to concerned friends or relatives; and this is over and above such obvious factors as race, religion, and education.

Is the average American more pragmatic than, say, the average Englishman? In a recent interview, for example, Richard Adams—the English author of *Watership Down*—said, "I was much struck, when I taught as a creative writer in residence at two American universities, with the way in which my students appeared to approach English poetry. They seemed to be all set to learn about it very much as they would have learned chemistry or carpentry. I used to hurl the book at them and say: 'For Christ's sake, why don't you cry?' You can only apprehend poetry emotionally, you can't study it as though it were agriculture."[3] Does the same thing happen when the American contemplates the problems of death and dying? By all means let us study and analyse these problems, but let us never be afraid of our emotions, our own gut feelings. Last year there was a newspaper story[4] about how Dr Christiaan Barnard wept after he told of a dying patient who had disconnected his life-support systems and had left the doctors a note saying "the real enemy is not death. The real enemy is inhumanity."

And how sensitive would an English or an American doctor be to the emotional needs of a dying Mexican? Mexico—where the film director Eisenstein found inspiration for an unfinished masterpiece (*Que Viva Mexico!*) because "the idea of death, indeed, was ever-present in Mexico. At first only Death Day itself had attracted him. But everywhere he found life emerging triumphant over death—death purging everything decrepit and obsolete and generating a new birth. Death and birth were closely interwoven at every step. . . . This, then, was the emotional context, this the sensory ambience, and this the landscape, 'carrying a complex of plastic possibilities for interpreting the emotions,' in which Eisenstein conceived his epic film—the film that was to remain tragically unrealised."[5]

I don't want to plunge into such deep waters as mercy-killing, but we are all familiar with those relatives who project their own distress rather than that of the patient. Dylan Thomas exemplified this attitude with his poem *Do Not Go Gentle Into That Good Night*; he hated to see his father—who had always been a fighter—give up the life force, and die meekly. But if this is what a dying patient wants to do, especially near the end of his illness, surely that is his right. The practical point is that we have to beware of those relatives who ask "can't you put father out of his misery, doctor?"—when, in reality, they are saying "put *us* out of *our* misery."

Concerning the matter of giving terminal patients whatever one thinks may be helpful to them, my feeling is that we should give them anything within reason. Let us even indulge, but infrequently and with great caution, in creative lying, if necessary—there is historical precedent for this: that great mediaeval French surgeon Henri de Mondeville (1260-1320), for example, said "if [the patient] . . . is a canon of the church,

Dr Wepfer's heart and great vessels. From *Observationes Medico-Practicae, &c*, Schaffhausen, 1727.

he is told whether true or false . . . that the bishop or prelate is dead, and that he has been elected; and that he should be thinking of arranging his residence and his personnel; that he is even to hope of later becoming Pope. He might be given, without compunction, false letters announcing the death or disgrace of his enemies, or of persons whose death will mean a promotion for him."[6] And Jung, in his autobiography, mentions how he lied to his dying father: "I had come home after lectures, and asked how he was. 'Oh, still the same. He's very weak,' my mother said. He whispered something to her, which she repeated to me, warning me with her eyes of his delirious condition: 'He wants to know whether you have passed the state examination.' I saw that I must lie. 'Yes, it went very well.' He sighed with relief, and closed his eyes."[7]

Wishes of the dying

Occasionally, dying requests may be difficult or impossible to fulfil—one thinks of the death of Robert the Bruce as recorded in John Bourchier's (Lord Berners) translation of Froissart's *Chronicles*: "I will that as soone as I am trespassed out of this worlde that ye take my harte owte of my body, and embawme it, and take of my treasoure as ye shall thynke sufficient for that entreprise, both for your selfe and suche company as ye wyll take with you, and present my hart to the holy Sepulchre where as our Lorde laye, seyng my body can nat come there."[8] Sir James Douglas was charged with this sad and difficult task and "enclosed the Bruce's heart in a silver casket, and hung it round his neck, and with a band of Scots set out to fight against the Saracens in Spain. But Douglas did not know how the Saracens fought, and in a battle against them in which they were put to flight, he pursued them too far and he and his men were surrounded. Taking the silver casket from his neck, he flung it before him, saying, 'Pass first in fight, as thou wert wont to do; Douglas will follow thee or die.' So saying, he rushed upon the enemy, and fell pierced with many wounds. After the battle, the silver casket was found under his body, as if his last thought had been that it should be safe, and it was brought home to Scotland and buried in the Abbey of Montrose. Douglas's body was also brought home and buried in his own church, near the castle of his fathers."[9]

Nevertheless, it is always a pleasing thing to see something done you know the deceased would have liked. Consider Johannes Wepfer, the great seventeenth-century pathologist who described the correlation between apoplexy and cerebrovascular damage. His friends brought out in 1727 a posthumous edition of his works, and this is a unique volume—after all, how many books have you seen which begin with a full account of the author's necropsy? The illustration (see figure) from the book suggests that Dr Wepfer's heart and great vessels were in a very shabby state indeed—many atherosclerotic plaques are evident.

Nice people die nice

Coming back to my first point—the need to be extremely sensitive to a dying patient's feelings, needs, background, intelligence, and so on—I believe that most dying patients tend to be essentially what they were during health, albeit alarmed, resigned, annoyed, or even indifferent to their impending demise. As Ned Rorem, the American composer, observed in one of his famous diaries, "When we see old people behaving cantankerously when they should be settling with God for a bit of final grace, it's because they were always cantankerous. . . . Nice people die nice."[10]

Or, more dramatically, consider the end of the gunpowder plotter Sir Everard Digby (1578-1606) as recorded by John Aubrey: "Sir Everard Digby was a most gallant gentleman and one of the handsomest men of his time. 'Twas his ill fate to suffer in the powder-plott. When his heart was pluct out by the executioner (who, *secundum formam*, cryed, Here is the heart of a traytor) it is credibly reported, he replied, Thou liest."[11]

All deaths are sad, and a few are horrible ("Ruth Yorck too has died, at the theatre while watching *Marat/Sade*. . . . A final cruel irony—the theatre audience mistook her dying agony for yet another directorial excess and looked away, embarrassed at her amateurish histrionics"[12]), and it is a very human reaction—much discussed by psychoanalysts—to find death a subject for humour. I am not thinking so much of the well-directed satirical darts of an Evelyn Waugh in *The Loved One* (against undertakers) or a Thomas Hood in *Mary's Ghost* (against grave-robbing), but rather of writers like Max Adeler (Charles Heber Clark, 1847-1915)[13]:

Four doctors tackled Johnny Smith—
They blistered and they bled him;
With squills and antibilious pills
And ipecac they fed him.
They stirred him up with calomel,
And tried to move his liver;
But all in vain—his little soul
Was wafted o'er the River.

Bathos is not uncommon in the literature of death, and a nice example is provided in James Foster's *Account of the Behaviour of the Late Earl of Kilmarnock, After his Sentence, and on the Day of His Execution* (London, 1746): "And I am informed of the following particular by Mr Home, that as he was stepping into the scaffold, notwithstanding the great pains he had taken to familiarise the outward apparatus of death to his mind, nature still recurred upon him: So that being struck with such a variety

of dreadful objects at once, the multitude, the block, his coffin, the executioner, the instrument of his death, he turned about, and said, 'Home, *this is terrible.*' "

If I should die . . .

As regards what dying people feel themselves, all of us should read W N P Barbellion's *Journal of a Disappointed Man*[14] and ponder its implications. Could a thanatologist have helped Mr Barbellion's troubled mind? I suspect not; but I'm glad there wasn't one around, for the world might have been robbed of a minor literary masterpiece. Here is an example of this young man's writing; he died in 1919, aged 31, after a long struggle against multiple sclerosis:

". . . Yet of a truth it is no use being niggardly over our lives. We are all of us 'shelling out.' And we can afford to be generous, for we shall all—some early, some late—be bankrupt in the end. For my part, I've had a short and boisterous voyage and shan't be sorry to get into port. I give up all my plans, all my hopes, all my loves and enthusiasms without remonstrance. I renounce all—I myself am already really dead."

A vastly different terminal philosophy from that of Barbellion is suggested by the following item from the *Los Angeles Times* (23 May 1978): "*The Ultimate Fan*: The man had a heart attack Sunday and was taken to a Seattle hospital. His first request in the coronary care unit was to watch the [basketball] playoff opener between the SuperSonics and the Washington Bullets. Then his heart stopped beating. Doctors worked feverishly to revive him. They succeeded but had to insert a tube in his windpipe. 'He couldn't talk,' Dr Scott Linscott said, 'but he motioned for a piece of paper and a pencil. He wrote that he wanted to know what the Sonics' score was. This from a guy that technically had been dead. Then he pleaded (in another note) for the nurses to let him watch the rest of the Sonics' game on television.' The nurses were hesitant but finally let him watch the Sonics win, 106-102. The man, whose name wasn't given, was reported to be resting comfortably Monday."

If I have a terminal philosophy myself it is that all of us are, or at any rate should be, thanatologists. I'm not just talking about the medical and allied professions—I'm talking about *everyone*. We're all in this together—in the words of that old chestnut, none of us are getting out of this world alive—so why aren't we more supportive of one another during life? In Saul Bellow's novel *Herzog*, Herzog observed that "life was life only when it was understood clearly as dying." And, of course, more than three centuries ago John Donne said it all so wonderfully: "No man is an island, entire of itself; every man is a piece of the Continent, a part of the main. . . . Any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."[15]

But let me end on a more cheerful note by recalling that the novelist John Updike once observed "we do survive every moment, after all, except the last one."[16] And concerning that last moment—or, rather, those last moments—let each of us strive professionally and personally to ensure that each dying person we encounter could say (as indeed did William Hunter, the great Scottish anatomist and obstetrician) at the end that "if I had strength enough to hold a pen, I would write how easy and pleasant a thing it is to die."

Part of this paper was presented at a seminar on Psychosocial Care of the Dying Patient held at the School of Medicine, University of California, San Francisco, 2-3 June, 1978.

References

1 Finch, J S, *Sir Thomas Browne*, p 266. New York, Henry Schuman, 1950.
2 *The Works of Sir Thomas Browne*, vol 1, p 166, ed G Keynes. London, Faber and Gwyer, 1928.
3 *UCLA Daily Bruin*, Los Angeles, 25 April 1978, p 12.
4 *Los Angeles Times*, 18 May 1978, p 13.
5 Barna, Yon, *Eisenstein*, p 172. Boston, Little, Brown, 1975.
6 Zimmerman, L M, and Veith, I, *Great Ideas in the History of Surgery*, p 144. Baltimore, Williams and Wilkins, 1961.
7 Jung, C G, *Memories, Dreams, Reflections*, p 116. London, Collins (Fontana), 1971.
8 *The Oxford Book of English Prose*, p 45, ed Sir Arthur Quiller-Couch. Oxford, Clarendon Press, 1966.
9 Brown, P Hume, *A Short History of Scotland*, p 96. Edinburgh, Oliver and Boyd, 1955.
10 Rorem, Ned, *The Final Diary*, p 26. New York, Holt, Rinehart, and Winston, 1974.
11 Aubrey, John, *Aubrey's Brief Lives*, p 96. Ann Arbor, University of Michigan, 1962.
12 Rorem, Ned, *The Final Diary*, p 164. New York, Holt, Rinehart, and Winston. 1974.
13 *A Century of Humourous Verse 1850-1950*, ed Roger Lancelyn Green, p 117. London, Dent, 1968.
14 Barbellion, W N P, *The Journal of a Disappointed Man*, p 85. London, Chatto and Windus, 1919.
15 *The Complete Poetry and Selected Prose of John Donne*, p 332. New York, Modern Library, 1941.
16 Updike, J, *Picked-up Pieces*, p 498. Greenwich, Connecticut, Fawcett Crest, undated.

A shush of librarians

GILLIAN M PENTELOW

"Can you find the first description of Hodgkin's disease before tomorrow?" "I would like to have a colour transparency of a picture in Zerbi's monograph on old age printed in 1489; there is a copy in the Vatican Library." "I want to quote 'Forty years on' at Dr Jones's retiring party but I must get the words right." "Some of our physiotherapy students will soon be starting their finals project, would you show them how to find appropriate references?" "I am working out a new research project, would you find out what has been written in the last five years on adverse effects of monoamine oxidase inhibitors?" These are typical queries encountered by a medical librarian—a shush of librarians, indeed.

For many years large institutions such as teaching hospitals, industrial firms, and universities have had their own libraries. Small hospitals have had haphazard collections of books and journals—some bought, and some given by generous members of staff. These "libraries" were usually looked after by busy secretaries, some of whom became efficient secretary/librarians; others were run, sometimes all too literally, on self-help. Medical staff who needed a more comprehensive library service relied on membership of the British Medical Association, Royal Society of Medicine, royal colleges, local medical societies with insufficient funds, such commercial libraries as H K Lewis's, or sought help from their teaching-hospital libraries. The staff of all these provided excellent services—as they still do—but the efforts required by the user and the fact that the answers to queries could not always be given immediately deterred all but the most enthusiastic.

Several factors combined to change this state of affairs. About 15 years ago some doctors realised that libraries were needed to supplement the district general hospitals' educational function. In the late 1960s the Todd[1] and Bonham-Carter[2]