Dealing with the Disadvantaged

Dealing with dying patients and their relatives

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The process of dying brings into stark focus the past, the present, and the future. In a short time the past must be reconciled and consummated, the present must be fulfilled, and the future must be planned, or at least probed. The doctor or health worker will observe in his patient the outward signs of this emotionally exhausting, painful, and often triumphant process in fluctuating emotional states and the expression of apparently irrational feelings. All emotions are intensified when the end is in sight.

A dying patient is increasingly dependent on family and friends. There is a complex interplay of discomfort, apprehension, and pain between those concerned. To understand we must meet and talk unhurriedly with the patient and with those closest to him, including children. This lays a foundation of trust on which subsequent interviews can build. If a patient and family fail to make this trusting relationship, like small children, they will be bewildered, or opt out, or be demanding yet never satisfied.

Points to consider

The following observations should be considered when communicating with dying patients and their families and friends:

(1) Few people these days have witnessed a death, except for those often dramatically and misleadingly portrayed on television. They need help in understanding the likely progress of the illness. Each symptom should be discussed and tackled as it arises, as should how it is hoped the death will occur. They also need simple directions as to what to do at each stage and who to telephone.

(2) The patient's distressing dependence and a rapidly changing body image requires us to discover the person he was and the dignity he expressed—and can yet express as a result of our concern and respect for him.

(3) Dying children often blame themselves for what is happening to them and for the sorrow and anxiety they see in their parents. They need a clear explanation of causation.

(4) Children often need reassurance about what will happen to parents (particularly a single parent) when they have gone, and need to be included in a plan to comfort and sustain parents.

(5) A parent finds it hard to explain to children about the terminal nature of the other parent's illness in such a way as to encourage questions. It is helpful for a doctor to answer those questions which can arouse overwhelming pain in the well parent.

(6) Patients young and old sense anxiety in those around them and "catch" it without knowing what it belongs to. This

free-floating anxiety is more fearful than that which is rooted in reality and openly discussed.

(7) Living near to death arouses complex kaleidoscopic emotions; these can be intensified by those aroused by earlier losses. Relief is found if these too can be expressed.

(8) Powerfully negative emotions of anger, remorse, bitterness, and hatred arouse anxiety. They must be accepted by the health worker without projection or criticism, and the patient and relatives must be helped to accept them as normal and to channel them into efforts to improve the quality of life that is left.

(9) Appropriate sadness must be distinguished from acute clinical depression. Sadness may reflect an acceptance of reality and thus a step towards a mature adjustment. A psychiatric referral at this stage can compound a family's problems, adding the feared stigma of mental illness.

(10) Much clinical depression in dying patients and their families seems to have its roots in a feeling of helplessness. But a sense of worth and meaningful control may often be acquired through discussing the illness and its treatment, assisting in nursing care, or creating diversional activities. Perhaps in our struggle to be "good" doctors and therapists and to do everything, we immobilise our patients and render them more helpless and more depressed.

(11) Many patients with cancer, and their relatives, still believe the disease to be contagious or hereditary or both but dare not share their anxiety. They also fear the hereditary effects of radiotherapy and cytotoxic therapy. I believe we need to give reassurance on these points before being asked for it.

(12) The memory of protracted physical pain or other severe symptoms, of a poorly understood illness arousing irrational fears, or of a sense of isolation with dread of sudden imminent death can remain and fester, preventing patients and families from making the most of the present. These fears may even persist after the patient's death in bereaved relatives as an emotional cancer undermining the survivor's capacity to cope with future living. Good total care from the beginning of the illness is of ultimate importance.

At routine medical examination of a non-smoking man the only clinical abnormality was a pulse rate of 100 at rest. Could this be due to his habit of using snuff two or three times every hour?

The peak concentration of nicotine is found in the blood five minutes after taking snuff, and the concentration falls to zero by 40 minutes.¹ Values resemble those found in heavy cigarette smokers, so the tachycardia could probably be caused by frequent snuff taking. But nicotine has a variable effect on the cardiovascular system, and it would be worth inquiring if he experiences any other symptoms of nicotine excess, such as nausea, dizziness, salivation, faintness, abdominal discomfort, or looseness of the bowels.

¹ Russell MAH, Jarvis MJ, Feyerabend CA. A new age for snuff? *Lancet* 1980;i: 474-5.