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The Attitude towards Disclosure of Bad News to Cancer Patients from 1676 to 1896

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Abstract

Disclosing the diagnosis or prognosis to cancer patients in Saudi Arabia was a serious challenge tackled in this Medical Journal. Accordingly, this article reviews the historical parameters of this problem. It has shown that there have been significant and various lessons.

Keywords Cancer; Tumour; Disease; Breast cancer

Introduction

In this Journal, Ali Aljubran [1] wrote recently that "The general attitude among physicians in the West in the recent past was not in favor of fully discussing the diagnosis or prognosis with patients." He exemplified at the start with a 1948 public survey done for the American Cancer Society concerning many aspects of public reaction to cancer. It was concluded that "Patients were viewed as extended family, and all decisions, including health-related decisions, are family-centered decisions."

Historical Texts from 1676 to 1896

It is intended to portray the historical pictures in chronological order. In this context, a physician with the curious name of Wiseman [2] may take the lead. His patient was a Lady with a swelling in her left breast. She had consulted fellow professionals and lastly sought Wiseman's opinion. The outcome was exemplary thus:

In progress of time they swelled, and, her Breast being extremely painful, she desired my Judgment of it. The Swelling was large and round, and greatly inflamed, under which it was soft, and seemed to have Matter in it. The Parts more distant were hard, and several Tubercles lying under the Skin made it unequal: yet the Breast was not fixed. She urged me instantly to deliver my thoughts of it: which to decline, I turned from her, and told her Friend it was a Cancer, and that I saw no hopes to save her life but by cutting it off. He wished me to consider how I delivered such Judgment of it, two Chirurgeons having lately assured her the contrary, they taking it for a Pblegmon. But I, not being used to guide my Judgment by what others delivered, confirmed to him what I had before said by a sad prediction, which befell her within few weeks after.

After tumors were complained about, the 1753 view of Norford [3] was that "the earnest entreaty of the patients, who have had the danger of a relapse fairly explained to them, and not the surgeon's persuasions, would make the extirpation to be undertaken." By 1769, Morgagni [4] discussed the case of a woman whose breast had been extirpated and then returned when "a small swelling began to be perceived under the skin." In this instance, it was the patient herself who said that "In this manner, the former tumour began: therefore came hither that this new tumour may be cut out, before it increases to any considerable size."

Size of the tumor should not be a deterrent although this should not be allowed to advance before surgery. This was the view of Bell [5] in 1784. As he reasoned: "For, as all the diseased parts affected can be safely separated from the sound, as nothing but their removal can afford any chance of safety, we must again say, that no hesitation should occur in advising the operation."

Operation may be consented to but delayed on account of psychological stress. In 1803, Hey [6] narrated how a woman "consented to the operation which I had proposed." However, there was a delay before submission for surgery because of "The uneasiness of mind which she felt from the apprehension of an operation."

Operation should follow guided principles. Home [7] enunciated them in 1805. In his own words,

The fact, which has only been lately established, should be made universally known, as being essentially necessary to guide us in our judgment, respecting the propriety of performing an operation; and I am ready to confess, that in all cases where the disease had arrived at that stage, in which it has acquired the power of contamination, I should be inclined, from the experience I have had, to doubt the success of the operation, and therefore would not venture to press it upon the mind of any patient, but, if the patient should desire the operation, I would not refuse to perform it…

It was appreciated that time was an important element in the doctor-patient relationship. In this context, consider the 1816 patient of Bell [8]:

When this young man had been a few days in the hospital, and when I had ascertained the disease to be that most mortal of tumours, the fungous tumour, called soft cancer, I informed him of his danger; he was surprised that I should consider it so seriously, but threw himself entirely into my hands.

Hands of surgeons had to be guided by their personal experiences. In fact, Sir Astley Cooper [9] lectured in 1824 thus:

I am anxious when a patient comes to me with this horrible complaint, in such a state as to afford her no hope from operation, to mention these examples. I am anxious to say to her, "Though your

complaint has arrived at that stage in which an operation will be of no avail, and though it is of that nature which does not allow of cure by medical means, yet I can tell you of many instances in which it has been exceedingly slow in its progress, and if you have your life prolonged ten or seventeen years you will be perhaps content." This excites a beam of sunshine in the breast, and a gleam of joy on the countenance; "Death," she then says, "is not so near as I expected," and her anxiety of mind is removed by the hopes which she has of the fatal event being procrastinated. It is right, gentlemen, in humanity, to mention these cases to patients labouring under this most distressing disease.

Disease as grievous as cancer needed more than just the doctor and the patient. There may even be a third party! In 1828, Seymour [10] used this approach. "I was," he said, "satisfied that the malignant growth was in the stomach itself, and accordingly informed the patient's friends." Then, he added that "this opinion was confirmed in consultation by Mr. Brodie and Dr. Chambers." Of course, this extra move was of additional importance.

Importance of the element of persistence in the consultation process was aptly described in 1837 by Warren [11]:

In the year 1830, a lady sixty years old, of fine constitution, informed me she had a small tumour in the left groin, about the size of a filbert, very hard, but not tender. I suggested it might be a rupture, or a disease of the glands, and proposed examination. She was averse to this, and determined to go on without doing anything, unless she had more trouble. After a few weeks she visited me again, and stated that she began to feel pain and that there was an additional tumour formed. I enforced the importance of an examination; intimating that it might be a most serious disease, and declining any prescription till I was satisfied of the nature of the swelling. Two or three months were allowed to pass over; the tumour extended; the pain increased, and the examination was submitted to. The result was the discovery of a hard tumour of about three inches superficial extent, and of considerable depth; knotted as if composed of many glands; and a little tender. I examined the abdomen above, and found a fullness and tenderness in the left inguinal region; convincing proof that the abdominal glands were diseased. It was obviously no case for a surgical operation, nor for medical treatment. But notwithstanding the former pertinacity of the patient in refusing to submit to a proper examination, I felt unwilling to notify her that she was under sentence of death.

Death stared another patient in the face but he would not budge even to the very end. In 1840, Neligan [12] told the stubborn story:

On arrival at the hospital I found him sitting up in bed gasping for breath; the veins of the face and neck swollen, the extremities cold, and the pulsation of the radial artery at the wrist to be felt with difficulty. I immediately proposed opening the larynx; but he refused to submit to any operation, and as, from the situation of the swelling, I was doubtful as to the relief which would be obtained, I did not persist. He inspires now with the utmost difficulty, and grasps his throat with his hands. His lips are livid, and the circulation seems to have nearly ceased in the extremities; but he still resolutely refuses to submit to any operation.

Operation may be performed on account of the very request of the patient. Thus, when he was the President of the Royal College of Surgeons of England, Lawrence [13] exemplified with an eye case. In his words, "the disease having steadily advanced, with intense and constant pain, the patient determined to have the eye removed at whatever risk."

Risk taking was considered by Velpeau [14] in 1856 in France:

When patients with such tumours come to consult me, either at the hospital or in private practice, whether alone or in consultation with other practitioners, I recommend no operation, and advise them never to submit to any. Either personally or through their families or friends, they apply to other practitioners who advise and practice the operation.

Operation was certainly much feared. For examples, in the case of a very large tumor of the breast handled by Bryant [15] in 1861, "He recommended her to come into the hospital and to have the tumour removed; but as she was "so much afraid of the cutting," she did not consent to the operation. Nine months ago, by the advice of some friend, she had the tumour painted over with iodine, and this treatment was carried on for six months, but without the least benefit.

Benefit is undoubtedly what the patient seeks. Sir William Jenner [16] in 1874 fully illustrated the quandaries:

An Italian gentleman came to me about twelve months ago. He was dying of cancer of the tongue. He was in the last stages of the disease, and in a most horrible condition. He had been under someone who had promised him a cure. He had then gone to Sir James Paget, who had not promised to cure him, but had told him that nothing could be done. This poor man told me, as well as he could, partly writing it down, that he had been cruelly used by Sir James in being spoken to so plainly. At the same time he wished me to speak plainly to him. I told him, of course, that he would die."

Die from cancer or survive after having it is at the bottom of all consultations. This was evident in the soulful review of Simon [17] in 1878:

I come to what I cannot but describe as hitherto matter for most painful contemplation. We practically have no treatment of cancer (in the sense of curative or preventive treatment) except such as consists in endeavours, in selected cases, to extirpate it with knife or caustic. In a very large majority of cancer-cases, probably more than three-fourths of the entire number, there can hardly be any serious thought of recourse to this one expedient; sometimes because of the original locality and perhaps visceral relations of the disease; sometimes because the cancer, since its origin, has made too much progress; and sometimes because of conditions concerning the patient's general health. To knife or caustic, the sole present resource of our art, we, therefore, can only resort in favour of the much smaller proportion (probably not as much as one quarter) of our cases. And, in regard of this favoured minority, what is the good which surgery can promise? First, it can promise a microscopical hope a hope which, on the whole, is so small as to be scarcely distinguishable from despair, that the disease will be radically cured by the operation. Secondly, it can hold out hopes, the exact nature and the strength of which will differ very greatly in different cases, but which, at their very best, are only hopes of palliation: sometimes the prospect that, under circumstances which otherwise threaten very speedy death, immediate, though only brief, respite will be obtained; sometimes the possibility (more or less) that such real check will be given to the disease as may sensibly affect the duration and (for longer or shorter time) the comfort of life; sometimes the object that particular local horrors of the disease will, if even only for a very short time, be abated. All this, taken at its best, is but poor measure of comfort for us to be able to give in respect of a disease so frequent and so dreadful as cancer.

Cancer was that year also deliberated on by Billroth: [18]

I consider it to be the duty of a surgeon, under certain circumstances, to deceive his patient as to the incurability of their disease whenever he considers an operation unadvisable, or when he declines to undertake it. The surgeon, when he cannot remove, ought to relieve the sufferings of his patient, both psychically and physically. Few persons possess that peace of mind, resignation, or strength of character, call it what you will, necessary to enjoy life quietly with the knowledge that they are the subjects of a fatal disease. Patients, outwardly calm, seldom really thank you for too plain a confirmation of what they secretly suspect. As a surgeon you will often be in difficulties in this respect, and each separate case must be left to your personal good sense, your knowledge of mankind, and your own good feeling.

Feeling for others has mattered a great deal. In his 1888 Lecture on cancer and cancerous diseases, Wells [19] instanced the problems encountered in amputation:

When a superficial cancer on a limb has returned after destruction by cauterization or caustics, or after removal by the knife and grafting of healthy skin, and the lymphatic glands nearer the body remain free from infection, the propriety of amputating the limb must become the subject for consultation. It will sometimes be the painful duty of the surgeon to urge upon a reluctant patient to sacrifice a limb in the hope of saving life; and if this advice is followed before infection of the glands has taken place, the result has often proved the soundness of the advice: while too great delay, or want of earnestness in urging submission to so serious an alternative as the loss of a limb must always be, may lead to protracted suffering and inevitable death.

Death was actually to be postponed as far as possible. This was sought in Glasgow practically by Beatson [20] in 1896. In sum, on the strength of his animal experiments, he was satisfied that hope would materialize through ablative surgery of the ovary in patients suffering from inoperable carcinoma of the breast. See how the conversation went:

I put it to her husband and herself as to whether she should have performed the operation of removal of the tubes and ovaries. Its nature was fully explained to them both, and also that it was a purely experimental one, but that it could be done without risk to life; and that, if it should have no effect on the cancerous process, it would cause her no increase of suffering. She readily consented that I should do anything that held out any prospect of cure, as she knew and felt her case was hopeless.

Conclusion

Modern times have witnessed the important question of patients' awareness and desire for information about malignant disease [21,22]. In this context, an international survey of physician attitudes and practice in regard to revealing the diagnosis of cancer was undertaken by Holland et al. [23]. They concluded that "It is important to recognize that efforts to find the "correct" position about revealing or concealing cancer diagnosis must recognize that the language between doctor and patient is constrained by cultural norms." Accordingly, I am persuaded that the general run of such attitudes has been presented in this review concerning the multitudinous encounters of cancer patients with the medical masters of yester years.

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