EDITORIAL

THANALOGY — THE STUDY OF DEATH AND DYING

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Editor

As the saying goes, two things are inevitable in this world — birth and death. Although doctors know a great deal about conception and the miracle of birth, death is still surrounded by mystic and silence until very recently. Recent interest in the subject of dying arises from fear of medical technology that can now prolong physiologic processes long after cognitive life has ended. We have now come to fear the technologic trappings of dying — the tubes, chemicals and machines — as much as the event itself. Another major factor contributing to this ignorance has been the traditional goal of the medical professional — that of preservation of life. An obvious implication is that death is the enemy and the epitome of defeat or failure. Fortunately during the last decade through the pioneering efforts of Dr Elizabeth Kubler — Ross (1) the subject of death and dying has received a fresh look and a whole new field of study call thanalogy has grown out of it. What then is the role of the doctor in the care of a dying patient. Perhaps the most important aspect is a shift in goals — from curing illness and preventing death to providing help throughout the dying process. The other important aspect is for the attending physician to understand the five basic stages patients experience emotionally after learning they are terminally ill. Patients may begin at any stage, may remain in one stage at all times, or may not progress from one stage to the next in the usual manner.

Stage 1 -- Denial (No, not me!). The patient may leave the hospital feeling that he or she does not have cancer or other serious illness and may look for other causes for the symptoms.

Stage 2 — Anger (Why me?). I have lived a good, clean life. What did I do to deserve this punishment.

Stage 3 — Bargaining (Yes it's me, but ...). Patients usually "asks" for more time to finish certain unfinished business.

Stage 4 — Depression (Yes, it's me). At this stage the patient does not talk much, usually lies in bed and eats slowly.

Stage 5 — Acceptance (Yes, I am dying. I want to be remembered by my family and friends. I need to get my affairs in order). This stage is the easiest to deal with for those who are involved with the patient.

The greatest problem for most dying patients is not pain but loneliness and isolation. Many dying patients are essentially left to themselves although they yearn to talk with others. Searching for love and compassion, the dying patient is left floundering in the sea of loneliness, filled with waters of misunderstanding, abandonment and despair. In a busy hospital they are often relocated to the end of the ward and doctors often walk past them in their daily rounds. Hospitals are, by and large, acute care facilities designed to receive the sick, get them through an episode of illness or surgical procedure and return them to society. They are, in short, way stations for the afflicted. It probably is inappropriate to expect an institution designed to "keep the patient moving" to double as a last stop for the dying.

What then are the alternatives. Dying at home may be one. Unfortunately not all families can cope with death at home. In this regard the trusted family physician is in a unique position to help. The dying patient's physical and emotional needs must be optimally met. Even the common thirst must be quenched, if necessary via the intravenous route. Being well-groomed and clean (so that a colostomy or drain site is odour free) influences outlook in a positive manner. Relief of pain is important. Too often doctors are concerned about the possibility of terminally ill patients becoming addicted to pain-relieving drugs. What difference does it make if a terminally ill patient with cancer required morphine every hour? The other option is the hospice movement which started in the U.K. and is attracting considerable attention worldwide. Historically, a hospice is an amalgam of hospital and hotel in which pilgrims could stop for rest and sustenance. It is dedicated to make the final days of patients proud and pain-free. This is accomplished by the skillful tailoring of pain medications to individual needs together with first-rate nursing. In Britain at the moment there are 81 hospices but like so many things quite a lot of them are plagued by lack of money and trained staff (2).

In the local context most terminal patients if given the chance would prefer to die at home. Unfortunately to-day's nuclear family are small and often separated both geographically and emotionally. Very often the one responsible for caring for a terminally ill patient is often left with no one to turn to for help. Our family physicians are woefully ill-equipped to look after the needs of terminally ill patients and their families. A workshop on "Terminal Care" with speakers from the hospice movement, thanalogists, social workers and members of the religious community would be a most timely and appropriate theme in a future medical convention in Singapore. The aim of the discussion is to maintain the highest quality of life possible during the terminal illness and to allow the dying person "to live until he dies." Although such a task is awesome, the period of terminal illness can be one of achievement, reconciliation and fulfillment for the dying patient.

REFERENCES

1. Kubler-Ross E et al: On death and dying. JAMA 1972; 221:174-9.
2. Smith T: Problems of hospices. Brit Med J 1984; 288:1178-9.