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Composition: Each uncoated, scored, light tan tablet contains spironalactone, 25 mg.

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Indications: Aldactone is indicated in the treatment of edema and ascites of congestive heart failure, hepatic cirrhosis, the nephrotic syndrome, and idiopathic edema as well as that due to malignant effusions especially if not responding well to conventional diuretics.

Aldactone also indicated for lowering blood pressure in essential hypertension, correcting hypokalemic alkalosis in severe hypertension and in the treatment of myasthenia gravis.

Dosage: Edema: the initial recommended adult dose is one 25 mg. tablet four times daily. Rarely a patient may require up to 300 mg. per day and others as little as 75 mg. per day. If adequate diuresis with Aldactone is not obtained within five days, Aldactazide should be substituted in its usual dosage to obtain the synergistic effect of the spirionalactone and the thiazide component. In an occasional patient with severe, resistant edema, it may be necessary to add a glycosidic diuretic to this combined therapy. In children, a dosage providing 1.5 mg. of Aldactone per pound of body weight should be employed.

Essential hypertension: One tablet four times a day treatment should be continued at least two weeks.

Precautions: Other than acute renal insufficiency there are no known contraindications to Aldactone. It should be used judiciously in patients with hypesthenia or hyperkalemia.

Side Effects: Side effects are mild and infrequent; drowsiness, mental confusion and maculopapular or erythematous eruptions have occurred rarely, subsiding within forty-eight hours on discontinuation of the drug. Gynecomastia and mild androgenic manifestations have also been reported in a few patients.

Toxicity: No reports of fatal overdosage in man. No adverse effects from high dosage in chronic animal studies.

Symptoms of Overdose: True toxicity has not been reported; drowsiness, mental confusion or a maculopapular or erythematous rash has occurred rarely. These manifestations disappear promptly on discontinuation of medication. Hyperkalemia may be exacerbated.

Treatment: No specific antidote. No true toxicity has occurred or is expected. Appearance of effects described above require only discontinuation of the drug. For hyperkalemia, reduce potassium intake, administer potassium-excreting diuretics, intravenous glucose with regular insulin or oral ion exchange resins.

Supply: Bottles of 100 and 500 tablets.

A clinical perspective on dying
Robert G. Janes, M.D., Stanford, California, U.S.A.

Summary: There is continuing need for dissemination of already available, clinically useful knowledge concerning the psychological needs of the seriously ill and dying. Against the changing social context of dying, some of our erroneous assumptions about these patients are explored and the genuine fears and personal needs are discussed. The implications of this knowledge for medical education are recognized.

Too little currently available information concerning the problems of seriously ill and dying patients is reaching primary care physicians. These patients constitute a largely neglected social group in an era otherwise characterized by intense interest in social minorities. The dying, for obvious reasons, are not a vocal minority. Death will never be fashionable. None the less the subject has received increasing attention recently by health planners, economists and sociologists. Rarely does this important literature focus on the principal object of these concerns, the experience of the seriously ill and dying person himself. It is as if it is more comfortable to speak of death rates and social rituals than about the very real and immediate existential dilemma of dying itself. Death remains a taboo topic that seems to exceed even sex in provoking a literature that tends to obscure personal issues and events. One can too easily lapse into metaphysics and popular religious clichés. Kubler-Ross and others have taken a patient-centred approach, much more useful in the tense, emotionally charged atmosphere surrounding the dying.

In my effort to highlight some of the available useful clinical knowledge on this subject I will initially examine the changing social context of dying. Against this background we can explore some of our erroneous assumptions about the seriously ill and, one may hope, reveal their genuine concerns, fears and personal;

cert avec cette modification, une pression négative peut devoir être instaurée pendant l’expiration. En dehors des changements physiologiques qui surviennent dans l’organisme, les risques provenant de défectuosités de l’appareil ou de son emploi erroné peuvent être catastrophiques.

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needs. Finally I will comment on the implications of such knowledge for medical education.

The changing context of dying
With the advent of technological medicine since 1900, fewer and fewer individuals die in familiar surroundings, on their own turf as it were, in sight of family relics and in reach of the ministrations of family and friends. Less than one-third of the nearly two million deaths in the U.S. this year will occur outside institutions. This transition from home to institutional atmosphere rudely divests the process of dying of its personal, evocative and historical elements elaborated over generations of bereaved families struggling to cope with impending loss. Further, the phenomenal treatment advances in medicine have largely reduced the impact of sudden or premature death only to produce a population paying for its longevity through the chronicity of its ailments. In our modern day parable, Lazarus appears not at the mouth of the grave but through the door of the intensive care unit. A death in the family today is more likely to provoke litigation than a religious justifying of the ways of God to man. "Nothing happens by itself anymore, there are no acts of God. Man is to blame for almost everything."

Assumptions about the seriously ill and dying
The first assumption is provoked by the very diagnosis of serious illness. For example, the word cancer in the minds of laity and professionals alike often elicits the unconscious equation: cancer = terminal disease. The implication is an early, perhaps grisly, demise. That this is untrue should be obvious. Many cancers are curable and we all rationally know this. But certain diagnoses (e.g. leukemia, cancer) evoke a kind of primitive fear in all of us that can paralyze reasonable action. Even in the most sophisticated medical communities extraordinarily primitive beliefs about cancer thrive. Several years ago I participated in a training workshop at Stanford for nurses and nurses' aides concerning the psychological care of cancer patients. Among the several hundred participants the greatest concern centred about the chance of "catching" cancer while working on the wards! It is hard to
imagine effectively caring for such patients in an atmosphere of suspected contagion.

Even physicians in varying degrees display their frequently unwarranted pessimism. Everyone knows of so-called “hopeless” cases which respond to the attentions of a particularly persevering physician who valued remission equally as cure. Families, too, occasionally sense a doctor’s defeatist attitude and, if strong enough, place their kin in another more therapeutically optimistic atmosphere. This is a seldom mentioned aspect of so-called “doctor shopping” in the face of critical illness. Not all such families are searching for a magical cure but rather are responding to a kind of hopelessness they detect in the physician’s demeanour.

A second assumption finds expression in the prevalent belief that medicine and nursing have little to offer the incurable or terminally ill patient except drugs to decrease pain and other kinds of discomfort. For some physicians the point at which they say, “I’ve done everything I can” is reached when the armamentarium of technical procedures is exhausted. At this juncture the patient is suddenly redefined from curable to incurable. Again another unconscious equation is evoked: incurable = beyond help. There are some subtle and not so subtle indicators of this transition. The code, DNR (Do Not Resuscitate), may be inscribed on the nurses’ medicine sheet. As time wears on there is a reluctance to make rounds on the dying patient. Generally he is moved to a private room or the drapes about his bed remain closed. Visiting privileges for family and fellow patients may be curtailed for the specious reason that he is too ill to tolerate their presence. As his seclusion increases his sense of isolation and worthlessness grows. This phase may be only days or might stretch for weeks. The physician may eventually receive only verbal reports from the nurse without actually seeing the patient.

The explanation for this retreat lies in the natural emotional resistance to contact with the dying encountered in medical staff and family alike. The anxiety provoked in the observers gains support from all quarters. The physician is confronted with his own helplessness and impotence in the face of inexorably progressive disease. The family members, perhaps having mixed feelings of guilt and unmanageable grief toward the dying person, may unconsciously avoid the sickbed. Under the guise of not upsetting the patient they escape their own discomfort.

The timing and pattern of professional retreat are variable. In a teaching centre the appeal of a disease process seems important. A patient with a truly exotic, even if fatal, malignant growth may have rounds conducted on him to the last minute and physicians can take refuge in intellectual bedside dissertations—a form of preoccupation with pathology in lieu of person. Doctors are frequently heard to say things like, “this is a beautiful example” of such and such a tumour with the emphasis on the word beautiful.

In sum, these powerful feelings provoked by proximity to the dying create an atmosphere of patient isolation and professional nihilism. This prevents us from encountering the dying patient on a personal level that will allow us to see what more we might have to offer besides drugs to decrease the important, but not sole distress of dying.

A final assumption we need to examine is the prevalent notion that offering truth to the dying only increases suffering, promotes depression and abolishes hope. Some even fear the risk of an unmanageable or perhaps suicidal patient. The equation here is: truth = suffering. It leads to the demeaning conclusion that a human being is unable to cope with the knowledge that he is about to die. It is no secret that persons with serious illness commit suicide. What is not clear is whether or not the knowledge of their disease is really an important factor in the suicide decision. Typically the information is confined only to some select family member. A survey of physician attitudes revealed that 88% of doctors generally don’t tell the patient the potential outcome of his illness. Yet 60% of these same doctors responded that they would want this information themselves if in a similar position. It would be valuable to speculate on the meaning of this discrepancy, but the consequences for the patient are more important. Bland reassurances and half-truths more designed to reduce the anxiety of the giver than the receiver become the patient’s fare. He learns not that he has cancer but “just a small lesion”, “a minor tumour” or a “bowel condition”.

In a sense this is what the patient, when first confronted with the bad news, will hear anyway no matter how explicit is his doctor. The universal phenomenon of denial immediately becomes operative. This is the psychological mechanism whereby intolerable reality issues are pushed from awareness. The reactions of cancer patients on being told their diagnosis have been studied. Of 231 patients who were told explicitly they had cancer, 19% subsequently denied receiving such information. It is more encouraging that two-thirds were grateful to know the truth. Only 7% resented the frankness.14 In truth, most patients suspect very early in their illness that there may be a fatal outcome and their inability to get accurate information about their status can lead to frightening and embarrassing circumstances. As their illness progresses, denial weakens and the patient without adequate knowledge is left free to speculate about all sorts of frightening possibilities in an atmosphere of clouded communication.

Not only does the patient deny, but, as previously suggested, doctors, nurses and paramedical personnel also protect themselves from the discouraging and even distasteful exposure to death and dying by this phenomenon of denial. Furthermore, a patient is quick to sense the denying doctor. A mutual pretense springs up in which both parties have the knowledge of probable outcome but the patient does not share his feelings for fear of offending or making uncomfortable his physician. I recall one outspoken patient with carcinoma who, after enduring a long course of surgical and irradiation therapy, bitterly accused his chronically platitudinous doctor of not being able to recognize a dying man.

All this foregoing is evasion of the question, to tell or not to tell. One cannot answer this question unless its form is changed, as Kubler-Ross suggests, to “How can I best share this knowledge with my patient.”16 The truth has many forms and the patient relies on his physician to present the news in an acceptable manner. There is no general formula. Much depends on a sensitive perception of patient needs and the doctor’s personal verbal style. The worst possible
response is a concrete prognosis in terms of time (which after all it is impossible for the physician to know) with explicit details as to the course. Patients' reactions to such news, however presented, is highly variable ranging from brute stoicism accompanied by practical business-like arrangements of important final matters to complete social paralysis and despondency. More commonly, though, the patient will want to think and then at a time of his choosing (not yours) talk, for you will have given him the opportunity to share his deepest thoughts.

**Concerns and fears**

It is at this time that the alert physician, nurse or aide, having escaped some of these self-protective assumptions about the dying, can listen and learn from the dying themselves the real nature of their concerns and fears.

Chief among these is not the fear of death itself, but of the process of dying, of anticipated pain and discomfort. This is much greater than the fear of impending extinction.

Closely allied to this is the fear of progressive destruction of the body ego, a particularly frightening prospect if a cosmetically important area is involved. This is a fear of becoming ugly and therefore unlovable and perhaps deserted while still alive.

We have mentioned the features of progressive isolation as the living prematurely retreat from the dying. The patient is acutely sensitive to this event. Dying is terribly lonely — only closeness and warmth help.

For some patients whose previous life styles showed great independence and self-control over their own lives, the worst feature of dying is loss of control, loss of personal mastery in the futile struggle against disease.

Inevitable, too, are the feelings of great personal loss, loss of life opportunities and life plans. This seems especially poignant for younger patients deprived of being able to reflect on a long and varied existence. Such a deep sense of deprivation may be disguised. Initially the keenly felt disappointment is projected to family and staff in angry outbursts alternating with depressive episodes. All this is an expression of sorrow not over the death to come, but for children, career aspirations, plans and possessions left behind.

**Needs**

Given these kinds of concerns on the part of the dying patient, concerns which can only be elicited by available persons in a setting of shared mutual knowledge, let us look now at what this dying human, in his final life crisis, really needs.

Foremost he needs to recognize the fact of serious illness or impending death but be given the opportunity to regulate the amount of revealing that is done, to be respected in his simultaneous need to know and need to deny and not to be cut off with reassuring platitudes or to be told in explicit disquieting terms the details of his situation. The patient always allows for hope even when the doctor does not. It is a common clinical experience that when the patient gives up, death soon follows. 14

He needs to have his seemingly trivial daily concerns attended to despite the larger reality of his diagnosis. For the dying, since the future is uncertain, the present assumes enormous importance. A patient with terminal illness might complain about ill-fitting false teeth and request a new set that would require six weeks labour. This is a way not only of avoiding thoughts of death but of dealing with the only conceptualizable realities he has. Hence the importance of the daily rituals of living: the morning newspaper, a special meal, the opportunity to live until you die.

He needs to feel he is the object of honest and ongoing importance on the part of family and professional staff, to feel that there is always something to be done, to receive an expression from his caretakers of a "we're in this together" attitude. It is great comfort to the patient to know his physician is in league with him against whatever manner of difficulty he might encounter.

He needs to have the opportunity to use the time left to him for resolution of important life issues. This may be the drawing up of a will, custody of children or reunions and leave-takings. Also important is the opportunity to discuss unresolved emotional conflicts peculiar to the individual. Obviously none of this is possible in an uninformed patient whose physician has not been able gently to communicate the meaning of his illness.

He needs to be allowed to grieve. While the bereaved family after the patient’s death may eventually be able to re-invest themselves in life tasks (the theme of "life goes on"), the dying patient needs to divest himself of life’s objects. This is a period of anticipatory grieving for the coming loss of objects and endeavours. This emotional preparation will culminate in the final stages when the patient, appearing depressed, is in fact void of feeling, without depression or pain. In this penultimate stage of the dying process silence, but not isolation, is indicated in the sickroom. The quiet human presence of family and friends is enough.

Some patients express a wish to leave behind, if possible, a gift, perhaps a piece of jewelry or a favourite book, with some significant person. This is a symbolic measure of the search for continuity, perhaps immortality. It is the leaving of a part of the dying with the living. Dying patients may bestow such tokens on their nurses and physicians and the knowledge of their meaning turns the acceptance into a healing event of great comfort. I have on my desk a favourite coffee cup from one such patient as a reminder of this wish.

Finally, I would suggest a major need of any dying patient is to find an acceptable answer to the question "Why me?" For those who are elderly or with firm religious beliefs the answer is less difficult. Some find comfort in feeling that their illness has been given meaning by participation in medical research. My experience has been that this finding of meaning is actually a greater problem for family or spouse than patient.

**Implications for medical education**

I have not mentioned here the important problems of dying children, the psychologica dilemma of the bereaved family or the circumstances of serious illness and death in the special setting of an intensive care unit or research centre. Each area has its own useful literature. 19-21 Although the ready availability of such information there continues to be insufficient infusion of this knowledge into the medical and nursing curricula. One cannot overemphasize the importance of introducing these charged issues early in training before students retreat behind the armour of technical medicine. Only a handful of teaching centres offer more than a cursory exposure to these problems. Yet the situation of
the seriously ill and dying patient offers rich opportunity for the introduction of students to the humanistic elements of medicine. Here one can redefine the role of physician as not just curing illness but helping the patient come to terms with his own life. It is an ideal forum for learning how major clinical and life decisions are made in concert with patient, family and life goals.

Some doctors today still bristle at such suggestions, fearing extension of their responsibility and involvement beyond the "scientific" aspects of patient care. However incongruous it may seem, today's physician, by virtue of his therapeutic prowess, the hospital setting of death and the increasing secularization of society, is viewed by many of his patients as both technical and emotional adviser. Dying is the important last life crisis that demands its own solution for doctor, patient and family alike. In helping to orchestrate an acceptable dénouement the physician participates in a process which enhances his contribution as practitioner of both the scientific and humanistic aspects of medicine.

Résumé

La perspective de la mort en clinique

Il importe de continuer à répandre nos connaissances actuelles, clairement utiles, sur les besoins psychologiques du moribond. Nous avons cru utile de confronter certaines de nos hypothèses erronées sur ces maladies avec les réalités sociales changeantes de la mort et de mieux comprendre les véritables craintes et les besoins personnels de ces maladies. Nous nous rendons parfaitement compte du rôle que doivent jouer ces notions dans l'enseignement médical.

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