This picture of Cicely Saunders will feature in an exhibition of photographs of doctors of the 20th century being organised by the *BMJ* and held at the National Portrait Gallery in London from 10 March 1997 (p 1633). There will also be a book.

NICK SINCLAIR

Dame Cicely Saunders today

ture or symbol or, perhaps most of all, in art and the unexpected potential for creativity at the end of life. Those who work in palliative care may have to realise that they, too, are being challenged to face this dimension for themselves. Many, both helper and patient, live in a secularised society and have no religious language. Some will, of course, still be in touch with their religious roots and find a familiar practice, liturgy, or sacrament to help their need. Others, however, will not. For them insensitive suggestions by well meaning practitioners will be unwelcome. How-

ever, if we can come not only in our professional capacity but in our common, vulnerable humanity there may be no need of words on our part, only of concerned listening. For those who do not wish to share their deepest needs, the way care is given can reach the most hidden places. Feelings of fear and guilt may seem insoluble, but many of us have sensed that an inner journey has taken place and that a person nearing the end of life has found peace. Important relationships may be developed or reconciled at this time and a new sense of self worth develop. A recent study shows how this may happen in late modern social conditions.⁸

My personal therapeutic journey has witnessed an extraordinary growth in drug treatments for pain and other symptoms. The challenge of educating others on their use remains. However, there has always been a human as well as a professional basis that is fundamental to the work that we do. Everyone meeting these patients and their families is challenged to have some awareness of this dimension. Professionals' own search for meaning can create a climate, as we tried often helplessly to do all those years ago, in which patients and families can reach out in trust towards what they see as true and find courage and acceptance of what is happening to them.

Research at St Joseph's and St Christopher's Hospices was supported by the Sir Halley Stewart Trust and the Department of Health and Social Security.

- 1 Saunders C. The treatment of intractable pain in terminal cancer. *Proceedings of the Royal Society of Medicine* 1963;56:195-7.
- 2 Twycross R. Choice of strong analgesic in terminal cancer care: morphine or diamorphine? *Pain* 1977;3:93-104.
- 3 Saunders C. The challenge of terminal care. In: Symington T, Carter RL, eds. *Scientific foundations of oncology*. London: Heinemann Medical Medical Books Ltd, 1976:673-9.
- 4 Saunders C. The care of the dying patient and his family. *Contact* 1972;38:12-8.
- 5 World Health Organisation. *Cancer pain relief*. Geneva: WHO, 1996.
- 6 World Health Organisation Expert Committee. *Report. Cancer pain relief and palliative care*. Geneva: WHO, 1990:11.
- 7 Keatney M. Palliative medicine—just another specialty? *Palliative Medicine* 1992;6:39-46.
- 8 Seale C. Heroic death. *Sociology* 1995;29:597-613.

Oh, for a little humanity

Sally Magnusson

Not many laughs this last fortnight. I went to visit a close friend in a hospital near London who had recently had a breast lump and her lymph glands removed. I found her curled like a fetus on her bed in one of those grim wards that seem positively designed to make you feel ill.

I was shocked by how utterly drained and beaten she looked. She had been home since the operation and had sounded quite perky on the telephone. Yet after being in this hospital for only a couple of days she looked finished.

Physically, it transpired, she was feeling not too bad; emotionally she was wrecked. Two days before, still weak from the operation, she had been invited to turn up at 10 00 am to learn the results of a scan. She waited all day. At 6 00 pm she was told that she had cancer of the liver and four small brain tumours. She seemed to have no idea what the treatment would be, whether it was worth having, what her options were, where she would have it, what the effects might be. To just about all of the hundred and one questions I asked her, she said: "I don't know."

"Haven't you asked the doctor?" I kept saying. Oh, she had tried. But he was so dry, so distant, always in such a hurry. It wasn't that he was rude, exactly, just

that he never looked her in the eye, never seemed to speak directly to her, just barked questions at the nurse over her head, and grunted in reply.

"I kept trying to focus on the right question, but the next minute he was gone. In and out like a whirlwind. It happens every time I see him. I get so confused. He flusters me. Nothing comes out right. I think he's taken one look at that scan and consigned me to the scrap heap. Three people have died in this ward since I got here. All I can think about is whether I'm going to wake up tomorrow.

"Am I going to wake up tomorrow?"

"Am I going to wake up tomorrow, Sally? Will I be here in a few weeks time? Can you look me in the eye and tell me that?"

I looked her in the eye and said, very slowly and wishing I knew more about the liver: "I am absolutely certain that you're going to be here in a few weeks time."

She relaxed, even smiled a bit, and began to talk about other things. I sat there wrestling with my rage.

Who was this man who called himself a healer yet could so effortlessly turn an illness into a trauma and so

Glasgow G1 1QP

Sally Magnusson, *journalist*

BMJ 1996;313:1601-3

casually crush a fragile spirit long before the body had done its worst? Do doctors like him have no imagination? Has familiarity with illness and fearfulness bred something worse than contempt? Has it atrophied their very humanity?

What had this man done? He'd done nothing. Precisely nothing. I honestly don't believe it would have ruined his schedule to treat her as an individual rather than the next in a line of diseased flesh, and encourage her to ask some of the questions he must have known were crowding into her mind. A couple of minutes spent looking directly at her, touching her hand maybe, goodness, even perching on the end of her bed, would have prompted her to burst out with the big question haunting her most: "Will I die tomorrow?"

He could have made the elementary steps towards forming a relationship, so that she felt the person in authority over her, the person in whose hands she had been obliged to place her life, was someone she could trust. He probably thinks that he's done his job by diagnosing correctly and ordering the right treatment; the counsellors can do the rest. But he has left behind a shattered woman.

The weakest fare worst

It infuriates me that it is always the weakest people, the least equipped to fight for themselves, who fare worst in hospitals. The articulate, the well informed, the brass necked, the ones with the money to have private treatment or the backing of tenacious families can play the system. They ask questions, they complain, they shop around, they demand second opinions.

It is the quiet ones who suffer, easily intimidated by authority and paralysed by their own humiliation, confused by illness or age, too nervous to ask the things they have a right to know, often simply too fearful to formulate questions whose answers they dread.

These are the ones, like my friend with no one but a 20 year old daughter to support her, who find themselves at the mercy of grumpy doctors, the brusque, uncommunicative type, too busy to talk, too superior to explain, too dense to realise that bedside manners are the heart of healing, not an optional extra.

I know that it must be hard for those harassed hospital doctors, who see dozens of ill people every day—none of them at their best, some of them querulous and slow to understand—to remember that each one is a human being with only one life that is infinitely precious to them and a spirit that can be bruised as easily as a butterfly by a steely reply or a curt brush off. But if they can't remember it they shouldn't be in the job.

Many, many of them do remember it. By the next day I had found another doctor, a respected cancer special-

ist in London, who was prepared to see my friend. Even down the telephone he sounded so nice I nearly wept in relief.

He fitted her into an already busy clinic and assured her she wasn't going to die tomorrow. He answered all her questions and maintained, I suspect, a discreet silence about the ones she didn't ask. He reassured her that he had studied the proposed treatment and agreed with it.

As far as I can tell, he neither pretended everything was going to be okay, nor offered the sort of blunt prognosis she didn't want to hear, but she went away knowing that she hadn't been discarded on some scrap heap of wasting flesh and that her life was valued.

This wasn't a private consultation or a not so busy hospital. It was simply a kinder man, whose eminence, intellect, and overloaded schedule have cost him neither his humanity nor his capacity to empathise with confused and frightened patients.

All down to personality

However much they try and teach bedside manners in the medical schools these days, I reckon it comes down to personality in the end. Unless we can somehow screen out the supercilious, the unimaginative, and the cold eyed before they hit the wards, the chances of being dealt with kindly when our lives are on the line will remain cruelly arbitrary.

The make up lady at the BBC encapsulated the problem rather neatly when I asked her if she had had a nice weekend. "No," she replied. "We had my nephew to stay. He's a medical student and he's so boring. Nothing to say, no interest in what anyone else is saying, no interest in anyone full stop. God help his patients when that one qualifies."

Postscript (some time later)

My friend died a week ago. She died in her own home, not many miles but a whole universe away from the hospital which forgot she was a human being. In the two weeks she was home, tended by a wonderfully attentive general practitioner, a big, cuddly district nurse, a Macmillan nurse, a Marie Curie nurse, her own daughter, and many friends. She was emotionally at ease and looked at times as near as you can get to happy when you know your life is ebbing fast.

When I saw her for the last time, supported by pillows in her living room, resplendent in a pink turban to cover her ravaged hair, I could hardly believe that this was the woman I had visited that first time in the hospital. She looked terribly ill, that's true; but the twinkle was back in her eyes, she was laughing, she had lost the defeated look that had so appalled me before. The hospital was far behind her.

"Sunrises" (12 August 1992) by Maggi Hambling

"Behind the altar in the chapel is the 'Resurrection' by Veronese in a wonderful baroque frame. Next to the chapel is a sanctuary—a non-denominational room for peace and meditation. An anonymous donor gave us £10 000 to decorate it. We had a competition and there were 10 submissions, and after a complicated selection process Maggi Hambling's nine images of Dawn at Hadleigh, Suffolk, painted on three separate mornings in August 1992, were chosen. In some strange way they seem to hover on the wall giving a very uplifting spiritual quality. I have, of course, no idea how sanctuaries should be organised, but ours seems quite successful."—JAMES SCOTT (see article, p 1634)

In today's post I found a letter from a doctor in Stirling who said she had been privileged to care for many patients with a terminal illness in the course of her work as a general practitioner. "Some time ago," she wrote, "while having a cup of tea with the family of a dying patient, his wife turned to me and said, 'I suppose you get used to this, Doctor.' The day I 'get used' to human tragedy is the day I will hang up my stethoscope and go home."

It was that kind of humanity from the medical profession that my friend found in her last days. It made the end of her life worth living and her death an easier thing for the rest of us to endure.

The article and the postscript first appeared in *The Herald*, which has given permission for them to be reproduced.

Don't leave a mess. Call Triple S!

Thomas Lynch

This extract is from "Uncle Eddie, Inc" in "The Undertaking—Life Studies from the Dismal Trade," a collection of essays by Thomas Lynch which will be published by Jonathan Cape in April. Lynch, the author of two books of poems, most recently "Grimalkin and Other Poems," operates a funeral home in Milford, Michigan.

Uncle Eddie needed an 800 number. His sideline in the suicide cleanup trade was going gangbusters. He needed a separate phone line, a logo, a slogan, and magnetic business cards. I was touched that he would come to me, his much older brother, for advice.

"Whadaya think about 1-800-SUICIDE? Too morbid? Too direct? Or 1-800-Triple S? You know. For Specialised Sanitation Services?"

In his heart of hearts he had hopes that Triple S—for Specialised Sanitation Services—would become as widely recognised as Triple A had for Automobile Association of America, or WWW had for the Worldwide Web, or Triple X had for a style of cinema that Uncle Eddie said excited his passion for First Amendment Rights. Though perhaps his services were a little too specialised—known only to local and state law enforcement agencies and county medical examiners and funeral homes and needed only by the families and landlords of the messy dead.

Indoor suicides, homicides, household accidents, or natural deaths undetected in a timely fashion—these were the exceptional cases that often required the Specialised Sanitation Services that Uncle Eddie and his staff at Triple S—his wife, his golfing buddy, and his golfing buddy's wife—stood ever ready to provide for reasonable fees, most often covered by homeowners' insurance.

"Maybe you should just play whatever numbers come up Ed." I counselled. "Maybe ask for something that ends in zeros."

At this Uncle Eddie's visage changed—adopting the distant and bedazzled gape of the ancient Mayan perplexed by the delicate mysteries of nothingness.

Years ago I would do it for free. I'd only been in town a matter of months when the chief of police called the funeral home in the middle of the night to ask if we had anyone on the staff who took care of "the messes...you know, the really bad ones."

"We've had a bad one over here on Highland Road. I just can't let his family back in the house until something's done with it. Really bad."

It seemed the late mortgagee of the split level home on Highland Road had grown weary of his wife's ongoing affair with the chiropractor for whom she worked. The chief had been able to piece it together from physical evidence and the widow's understandably agitated testimony. The cuckolded householder had sat up drinking after his wife had gone to bed, announcing her intention to put spongy rollers in her hair. This had

become an intimate code that meant she did not want to have sex with him but wanted to look good for the boss tomorrow. He'd finished the bottle of Dunphy's Irish and raided her stash of Valium, then gone to the drawer where the Black and Decker electric carving knife was kept between Easters and Thanksgivings and Christmases. He'd plugged it into the wall socket on his side of the bed, locked his jaw against any utterance, and, laying down beside her, applied the humming knife to his throat, severing his carotid arteries and making it half through his oesophagus before he released his hold on the knife's trigger. It had not been his coming to bed, nor the buzz of the knife, nor any sound he'd made that woke her. Rather, it was the warmth of his blood gushing from his severed vessels halfway up the master bedroom wall and soaking her and her spongy rollers and saturating the bed linens and mattress and box springs and puddling in the carpet beneath the bed that woke her, wondering was it just a dream.

Determination

We washed and scrubbed and wiped until daybreak. And after much suturing and the use of a turtleneck sweater, predicted the possibility of an open casket, though nothing could be done about the dead man's mouth, which was clenched in the way you see in the movies when they give the wounded hero a bottle of hooch and a bit of leather to chew before they remove the bullet or the leg that the bullet was shot into.

The poor client looked, as a cousin several times removed remarked, "determined."

This is the part I have always admired—the determination, the pure resolve, to do one's self such massive and irreparable damage, which is the distinguishing element of all successful suicides. It distinguishes the true killer from the occasionally suicidal. Who among us in our right minds hasn't yearned several times in the course of life for the comforts of absence and non-being? But there is a subtle and important difference between those of us who'd rather not be alive tomorrow—incomplete homework, biopsy results, romantic reversals, pregnancy tests—and those of us who want to be dead, tomorrow and the day after and forever. The latter is the exception; the former, the rule.

To kill a member of one's species—be it oneself or another—calls for a deadly silence, however momentary, of all the voices raised to the contrary. As anyone who has swatted a wasp, or caught a fish, or shot an animal, or sat with the dying of our own kind knows, life—at the cellular level—rages against the dying of the light. Something in us argues, "Don't!"

Don't leave a mess. Call Triple S! is the slogan Uncle Eddie invented. He had it printed in 22 point bold Mead gold letters on a dark green background along with his 800 number (1-800-668-4464) and made into kitchen magnet cards, and he mailed them out to police

328 East Liberty, Milford,
MI 48381, USA
Thomas Lynch, funeral
director, writer
Email: thoslynch@aol.com

BMJ 1996;313:1603-5