HEALING ARTS

Text and Context

Terminal (Mis)diagnosis and the Physician–Patient Relationship in LM Montgomery's *The Blue Castle*

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LM Montgomery's *The Blue Castle* was first published in 1926, yet contains many insights into medical practice that remain relevant today. The protagonist, Valancy, mistakenly receives a terminal diagnosis in a letter from her physician, who has sent her a note intended for another patient. Her interactions with the physician raise issues that are still relevant in contemporary medical education and practice, primarily the importance of effective communication in the physician–patient relationship, especially in the context of diagnosing terminal illness and handling a diagnostic error. *The Blue Castle* offers a useful starting point for debate and discussion in medical education about these topics.

KEY WORDS: communication; terminal diagnosis; physician–patient relationship; empathy.

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EXCERPT FROM LM MONTGOMERY'S *THE BLUE CASTLE*¹

[Valancy] almost thought she would go and see Dr. Trent about that queer pain around the heart. It had come rather often lately, and the palpitations were becoming annoying, not to speak of an occasional dizzy moment and a queer shortness of breath. But could she go to him without telling any one? It was a most daring thought. None of the Stirlings ever consulted a doctor without holding a family council and getting Uncle James' approval. [...] She did not want any one to know about her heart. There would be such a fuss made and every member of the family would come down and talk it over and advise her and caution her and warn her and tell her horrible tales of great-aunts and cousins forty times removed who had been "just like that" and "dropped dead without a moment's warning, my dear."

[...]

Dr. Trent was a gruff, outspoken, absent-minded old fellow, but he was a recognised authority on heart-disease, even if he were only a general practitioner in out-of-the-world Deerwood. Dr. Trent was over seventy and there had been rumours that he meant to retire soon. None of the Stirling clan had ever gone to him since he had told Cousin Gladys, ten years before, that her neuritis was all imaginary and that she enjoyed it.

[...]

She had almost decided that she would go home, instead of going to see Dr. Trent. Her courage had failed her. She was afraid of offending Uncle James—afraid of angering her mother—afraid of facing gruff, shaggy-browed old Dr. Trent, who would probably tell her, as he had told Cousin Gladys, that her trouble was entirely imaginary and that she only had it because she liked to have it. No, she would not go; she would get a bottle of Redfern's Purple Pills instead. Redfern's Purple Pills were the standard medicine of the Stirling clan. Had they not cured Second Cousin Geraldine when five doctors had given her up?

[...]

The ordeal was not so dreadful after all. Dr. Trent was as gruff and abrupt as usual, but he did not tell her her ailment was imaginary. After he had listened to her symptoms and asked a few questions and made a quick examination, he sat for a moment looking at her quite intently. Valancy thought he looked as if he were sorry for her. She caught her breath for a moment. Was the trouble serious? Oh, it couldn't be, surely—it really hadn't bothered her much—only lately it had got a little worse.

Dr. Trent opened his mouth—but before he could speak the telephone at his elbow rang sharply. He picked up the receiver. Valancy, watching him, saw his face change suddenly as he listened, "Lo – yes – yes – what? – yes – yes" – a brief interval – "My God!"

Dr. Trent dropped the receiver, dashed out of the room and upstairs without even a glance at Valancy. She

heard him rushing madly about overhead, barking out a few remarks to somebody—presumably his housekeeper. Then he came tearing downstairs with a club bag in his hand, snatched his hat and coat from the rack, jerked open the door and rushed down the street in the direction of the station.

Valancy sat alone in the little office, feeling more absolutely foolish than she had ever felt before in her life. Foolish—and humiliated. [...] Not only was she a failure as a relative and non-existent as a sweetheart or friend, but she was not even of any importance as a patient. Dr. Trent had forgotten her very presence in his excitement over whatever message had come by the telephone.

[...]

Dr. Trent's letter was like himself—blunt, abrupt, concise, wasting no words. Dr. Trent never beat about the bush. "Dear Miss Sterling"—and then a page of black, positive writing. Valancy seemed to read it at a glance; she dropped it on her lap, her face ghost-white.

Dr. Trent told her that she had a very dangerous and fatal form of heart disease—angina pectoris—evidently complicated with an aneurism—whatever that was—and in the last stages. He said, without mincing matters, that nothing could be done for her. If she took great care of herself she might live a year—but she might also die at any moment—Dr. Trent never troubled himself about euphemisms. She must be careful to avoid all excitement and all severe muscular efforts. She must eat and drink moderately, she must never run, she must go upstairs and uphill with great care. Any sudden jolt or shock might be fatal. She was to get the prescription he enclosed filled and carry it with her always, taking a dose whenever her attacks come on. And he was hers truly, H. B. Trent.

Valancy Stirling lives a cloistered, fearful life when she sees a physician about heart pain. During their appointment, Dr. Trent leaves abruptly when he hears that his son is seriously injured, and later sends Valancy a letter stating that she has a fatal heart condition and will die within a year. After a year she visits Dr. Trent again, and learns that in his anxiety over his son he mistakenly sent her a letter intended for another patient, Jane Sterling, while Jane received Valancy's diagnosis of "pseudo-angina. It's never fatal—passes away completely with proper treatment" (p.182). Valancy's belief in her impending demise frees her to find happiness in a new life; of Jane Sterling, ignorant of her fatal disease, we hear little else.

The Blue Castle was first published in 1926, yet many of its insights into medical practice remain relevant. One key issue arising from these excerpts is the complexity of effective communication in the physician-patient relationship, particularly in the context of terminal diagnosis. Although physicians have a vital role in communicating issues relating to

terminal diagnoses, they do not always receive adequate training in delivering bad news or negotiating treatment plans in the setting of fatal illness.² Meaningful communication in end-of-life care demands sensitivity and understanding from the physician, avoiding "inept phrasing"², (p.3052) that may undermine a patient's trust in the physician. One factor influencing physician-patient interaction can be the physician's own values and feelings, which may include inadequacy or guilt, among other emotions.³

We see this struggle exemplified in Dr. Trent, who apologises for his "unpardonable carelessness" (p.182), and "to the day of his death he was ashamed of putting those letters into the wrong envelopes" (p.184). He is less concerned, however, with the consequences of his mistake for his terminally ill patient Jane:

She must have got your letter—telling her there was nothing serious the matter. Well, well, it couldn't have made any difference. Her case was hopeless. Nothing that she could have done or left undone could have made any difference. [...] I hated to tell her the truth. You think I'm a blunt old curmudgeon—and my letters are blunt enough. I can't soften things. But I'm a snivelling coward when it comes to telling a woman face to face that she's got to die soon. [...] She died two months after she was here—died in her sleep. My mistake couldn't have made any difference to her. But you! I can't forgive myself for inflicting a year's misery on you. It's time I retired, all right, when I do things like that—even if my son was supposed to be fatally injured. Can you ever forgive me? (pp.182–3).

Dr. Trent's error may have made some difference to "poor old Miss Sterling" (p.182), however, if only in that knowledge of a terminal diagnosis may allow patients the opportunity to organize the last days of their lives, even if no medical difference is possible. Balaban⁴ identifies four steps for physicians discussing end-of-life care with their patients: initiating discussion, clarifying prognosis, identifying end-of-life goals, and developing a treatment plan. The goal-setting stage may include physicians exploring with their patients both medical (advance care planning) and non-medical goals. While goals may be similar for many terminal patients, including prioritizing time with family and reducing unnecessary medical treatments,⁴ there may be multiple, contradictory goals, and goals can change over time.² In the world of *The Blue Castle* we may wonder whether Jane Sterling's ignorance of her approaching death truly made no difference in her life, as Dr. Trent claims. In the real world, we must respect patients' right to plan their last days and, where possible, help equip them to do so. The support, advice, and resources available to terminal patients may have evolved since the time of writing *The Blue Castle*, but the implications of allowing patients dignity and autonomy in their final days remain critical.

Dr. Trent's communication problems reflect current concerns regarding empathy in medical education. He rightly implies he ought to have diagnosed Jane in person rather than in a letter, but though regretful, laments his inability to remain unemotional and detached rather than the implications of his approach for his patient. Castigating himself for being a "snivelling coward" who "can't soften things" (p.183), Dr. Trent highlights the difficulties of disclosing a terminal

diagnosis to patients: the (perhaps self-imposed) expectation that physicians remain objective and unmoved while at the same time offering empathy to the patient. Lacking empathy is, of course, anathema to current ideals of communication in contemporary medical education, particularly considering the well-documented, if increasingly debated, declines in empathy in medical students.

However much we may agree with such sentiments, Montgomery reminds us that respect in the physician–patient relationship is not always easy. Dr. Trent’s communication skills in terminal diagnosis lack finesse, yet his curt assessment of Cousin Gladys’ illness as “all imaginary and that she enjoyed it” (p.10) is also troubling, if also an apt and entertaining characterization. Modern fictional patients regularly meet with ridicule at the hands of physicians, as in the highly popular medical television program *House, MD*. From the straightforward bluntness of Dr. Trent to the overt contempt of Dr. House, then, such fictional communication with patients may perhaps function as an ongoing “wish fulfilment”⁵, (p.98) for real-world medical practitioners obliged to engage with a range of patients whose illness may seem to owe more to hypochondria than genuine disease. Clinicians may find such imaginary interactions amusing precisely because they recognize the need to grapple in more respectful and challenging ways with the complexities of appropriate physician–patient interaction in the real world.

DISCUSSION QUESTIONS

1. What are some of the ways you can prepare both yourself and your patient for disclosure of a terminal diagnosis?
2. If an error is made in the diagnosis or treatment of a patient, how might you communicate this to them? What impact do—or should—other issues (ethics, legal

implications, other circumstances) have on the process of error disclosure?

3. How might you adapt your communication when dealing with different types of patients—some who may feel significant anxiety as they see you, others whose symptoms may seem exaggerated?

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