Typical Patient and Family Attitudes

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The patient's reaction to terminal cancer depends upon his chronological age, his emotional maturity, his general patterns of behavior, his typical reactions to stress and crisis, his family constellation and relationships, his economic situation, and his relationships and activities as a member of society. Interwoven into this composite pattern is his knowledge of cancer in general and of his own illness and its probable outcome, and his previous experiences with medical care. The attitudes and reactions of the family will be determined by some of these same psychosocial factors as well as by feelings about the specific member who has cancer.

The patient may have suspected cancer because of his symptoms and perhaps because other members of his family had it. Or he may have had no suspicion that his symptoms were related to cancer. In either instance, he will probably undergo shock when he guesses or receives the diagnosis. If the information is given by an understanding physician, he will be permitted to react to the shock with tears, disbelief, expression of hopelessness, with anger, or other typical reactions to crisis. Then, with the relief of expressed emotion, he may be able immediately to mobilize his personal resources to proceed with the recommended medical regimen. If so, he will have incorporated his illness into his life in its proper place—to have cancer, not let cancer have him.

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Reactions Vary

Everyone is not able to make so rapid a response. Some react with self-blame for the fear or reticence which kept them from seeking medical care early. Some, mystically, seek some wrong which they committed to deserve such punishment. Some react with hostility toward their families because other members had the disease. Some project blame onto physicians who failed to make an accurate diagnosis or did not tell them the diagnosis. Others are furious at a society in which they are unable to purchase adequate medical care or which requires the expenditure of large sums of money without providing cure. Frequently, sufficient relief and better perspective comes from talking out these feelings with a professionally qualified person if family or friends are too close to be of help or the patient does not want to disturb them. Periodic opportunity to get this kind of relief from tension has helped many patients find the positives in their situations, focus on them, and carry on self-reliantly.

The Adjustment

Patients with terminal cancer learn to live with the knowledge of death in the foreseeable future. A comparative few are hopeless—living constantly with a specter while they wait for actual death. Some sink into depression, some into martyrdom. Some become controlling and dominating, and some drive themselves relentlessly in search of a cure. Others talk

frankly of the reality of death as part of life in its proper perspective. To some it is an anticipated release from suffering for themselves and their families. Many find diversion and a sense of satisfaction in taking practical steps to arrange their affairs and plan for and with their families. Most families need encouragement to let the patient share this responsibility rather than overprotect him.

Sometimes physicians also need such encouragement. One patient was made much more comfortable in his last hospitalization when, following the medical social worker's explanation of his need and desire for specific information, his physician was frank with him regarding his life expectancy, gave him a pass for several days so that he might arrange his business affairs to provide for his wife's future and his son's completion of college, and attend his daughter's wedding.

Other patients have wanted to be part of the planning and process of obtaining financial assistance or other social agency services. Young mothers have had release from much anxiety through persuasion of their families to let them participate in plans for the children so that the family might be kept intact after the mother's death. The families, too, have learned to live with, but uncontrolled by, the knowledge of death.

Religious faith has sustained both patients and families. Early contact with the proper clergyman is important to prevent the frightening feeling of "last rites" upon his appearance. One entire medical team, and particularly the medical social worker, worked long and hard to help one of the most restless patients find the religious faith and particular church in which she could have not only comfort, but also an opportunity to serve—an intercultural, interracial organization. Some patients develop the most positive philosophy of life they have known by filling each day full of as interesting living as their strength will permit. Some become altruistic and want their experiences, and even their bodies, to increase the knowledge of cancer for the benefit of others.

The attitudes of the patients and families are frequently determined by, or determine, the kind of care which is available and acceptable to them. It has become almost a truism in social work that, except for the comparatively few really destructive situations, people are most satisfied in their own homes. This has been found to be true of patients with cancer. Frequently, adjustments need to be made to facilitate care at home. Anxieties need to be relieved through explanations of the illness and care of the patient, through financial supplementation, through housekeeping assistance, through furnishing of supplies, and through periodic relief for the member caring for the patient. Great security comes from the knowledge of the certainty of visits by physicians and nurses and of the availability of hospitalization when it becomes essential.

Care at Home

Mothers have been maintained at home until within days or hours of their deaths by such services and the emotional support given them and their husbands and children by social workers and others. While the visiting nurse was caring for one mother, the social worker helped her son play and talk out his fears at the sandpile in the back yard. She explained about the visiting housekeeper and the plans for his mother's care and she gave him her business and home telephone numbers so that he might have the neighbor call when his mother became worse and his father could not be reached.

But what of lone patients who do not have families to care for them? They, too, want to maintain their usual living habits. Frequently, it is the physician who is most apprehensive about letting them stay home and who needs assurance from the social worker that adequate arrangements have been made for observation and care.

One patient maintained herself and her apartment through the purchase of a refrigerator and arrangements for weekly shopping by a neighbor. Another patient was able to stay in his hotel room because the hotel clerk, assured that cancer is not "contagious," offered to "keep an eye on him" and keep in touch with the clinic. A third not only maintained himself in a hotel room following a tracheotomy (he did not have a hemorrhage) but went back to his job as a cook in a tuberculosis sanatorium, where he would not be seen by too many prying eyes nor have to talk much.

Final hospitalization may be distasteful because it so frequently means care in county hospitals which, even though adequate medical and nursing care may be available, are overcrowded and can give little personal attention. Patients and families have many times been helped to accept such hospitalization for the value of medical and nursing care, when they cannot afford expensive nursing home care. The personal attention can be supplemented through visits and services of family and friends.

The attitudes of patients with terminal cancer and of their families are as varied as the people who have them. On the whole they are attitudes of great strength of people facing a difficult reality with their own and the resources put at their disposal by those who wish to share with them. Their positive philosophies of life have influenced those of us who know them toward more constructive attitudes of our own. The attitudes toward cancer of all of us will, in turn, condition the attitudes of other patients and families. They can, and should be, positive.

United Nations Day, October 24

The President of the United States has designated October 24, 1952—seventh anniversary of the coming into force of the charter—as United Nations Day. The formal proclamation notes that "the founding of the United Nations has given the people of the world an organization through which nations may resolve their differences without resort to war and has made possible greater international cooperation in the economic, political, and cultural fields."

"Realization by citizens of other nations," President Truman said, "that the overwhelming majority of Americans support the United Nations and its great purposes would help to speed the day when there will in fact be peace on earth, good will toward men."

The Secretary-General of the United Nations, in a message, points out that "today it is only too clear that we are still far from achieving these ends. We live amid bitter ideological differences, massive conflicts of power, localized fighting, and the danger of a world war which may wipe out civilization.

"This is a situation which we must face squarely," the Secretary-General emphasized, "but we must also note what we have attempted and achieved. . . . We see major failures and setbacks, but also persistent effort. We see good beginnings and some achievement in almost every field.

"However, these are only the first steps towards goals never before reached. Faith and work for many years is needed to eradicate the age-old evils of war, poverty, and inequality. This perspective we must always bear in mind."