

Prevention of gloom among cancer patients: a historical review

Abstract

The concept of 'humane healthcare' is of considerable interest nowadays. For elucidating and making it functional, it is necessary to reflect on the historical conditions in which modern healthcare finds its roots. Therefore, this paper reviews healthcare opinions in terms of the humaneness which drove away gloom during cancer surgery from 1635 to 1896.

Keywords: cancer, humaneness, healthcare, parameters, history

Volume 3 Issue 2 - 2015

Wilson Onuigbo

Department of Pathology, Medical Foundation and Clinic, Nigeria

Correspondence: Wilson Onuigbo, Department of Pathology, Medical Foundation and Clinic, 8 Nsukka Lane, Enugu 400001, Nigeria, Tel 2.35E+12, Email Wilson.onuigbo@gmail.com

Received: June 24, 2015 | **Published:** October 13, 2015

Introduction

Humaneness has been defined in terms of compassion, sympathy, or consideration for humans. Recently, a Scandinavian Journal carried the Supplement on Humanity and Medical Responsibility, being the 7th International Congress of the International Medical Association for the Study of Living Conditions and Health. Actually, Pijenburg¹ put it thus: "In a very general sense we could say that humane refers to what is fitting for a human being." Moreover, as Frewer & Rothaar² editorialized, "The medical and healthcare communities stand at the forefront of fundamental challenges." It seems appropriate, therefore, that its historical roots deserve documentation.

Historical texts

Documentation may begin with the hopeless cases which abounded in many cancers. For example, concerning the eye, we gather that Coote,³ an eye specialist, emphasized that the removal, i.e., the "extirpation of the eye ought never to be undertaken, except at the patient's express desire, and after he has been fairly made acquainted with the circumstances of the case." Way back, le Dran,⁴ another cancer specialist, generalized that "extirpation, if even there should be a return of the disease, may prolong the patient's life," adding that "it might not be amiss to propose it; giving at the same time such an outcome of the event, as may secure both the surgeon and his profession from reproach if a return should ensue." In other words, the pros and cons were to be put squarely. Thus, as Morgagni⁵ wrote, the doctor has to "propose on one hand, the successful instances of their extirpation, many of which he had seen; and, on the other hand, the examples wherein there had been great fear and danger, which he was likewise not ignorant of: and then to leave to the discretion of those who consulted him what they should do, without interposing any judgement or persuasion of his own." William Norford,⁶ who agreed with presenting both good and bad results of surgery, accepted that "the earnest entreaty of the patients, who have had the danger of a relapse fairly explained to them, and not the surgeon's persuasions, would make the extirpation to be undertaken." The result of such an explanation was furnished by Wiseman⁷ whose experience was that the patient replied: "God's will be done. I pray, go and consider of the way: for I had rather die than live thus." Thus wrote Warren⁸ concerning a long case report which is pertinent today: "...the patient's health was failing, and his suffering from the act of swallowing, quite distressing. What was to be done in this case? My first impression was not favourable to a surgical operation.

On the other hand appeared the prospect of a lingering and inevitable death. The patient, finding an increase in his sufferings, became more desirous of an operation. I then agreed to submit the case to a consultation of the surgeons of the Hospital, and if they should determine that an operation acquainted with the danger and uncertainty of a surgical operation, and that, if after a view of these, he desired it to be done, it was right to undertake it. The patient, after a consultation with his friends, determined to go through it, and it was performed.

Performed for the good of the patient, operations were guided by several humane considerations, including proper hospitalization. For instance, regarding staffing, the person in charge "took particular care to have also a nurse who was in good health".⁵ Indeed, there was a wide range of beneficial options. Thus, care was taken not to operate on a poor risk patient.⁹ Similarly, operation was postponed until breathing problems subsided.¹⁰ Doctors were urged to avoid "blunder";¹¹ to proceed "methodically" Morgagni;⁵ to exert greater care in preventing fatality;¹² to take pains to improve on one's operating procedure;¹³ to recommend operation as early as the illness required it;¹⁴ to deal rapidly with the situation if "the patient was taking the an aesthetic very badly";¹⁵ and, as Lack¹⁶ advised, one must remember that "everything, which may happen during an operation, is to be well considered and provided for, even by the oldest and most experienced surgeons."

Surgeons who had become well experienced were urged by Wiseman⁷ to teach their juniors how to be "more cautious" in undertaking cures. In his book, Pearson¹⁷ called for decisions based not only on "ample and learned experience" but also on "minute exactness." Later, Earle¹⁸ said cautiously, "I will not attempt, as it is almost impossible to express in words those nice powers of discrimination which can only be gained by experience." Little wonder that Travers¹⁹ affirmed that accurate knowledge gained from experience "would be an important attainment in surgical practice." On his own part, Freind²⁰ had spoken in favor of the surgeon who "always made himself master of the nature of the case, and considered the probability of success, before he attempted the operation in any of these dangerous diseases."

Diseases must be so situated that, as Macbride²¹ concluded, the afflicted portion "can be completely removed without material injury to the rest of the body." In fact, Gross²² grasped it nicely a century later: "In selecting an operation the golden rule should be observed to

go as far as possible from the seat of the disease, without needlessly jeopardizing life." Indeed, Hutchinson²³ defined the duty of the surgeon in terms of operating "whenever feasible." For example, feasibility, in the case of brain surgery, according to Knapp,²⁴ must involve opening the skull, and cutting through its coverings or else it would be "like hiring a locksmith to open a trunk box in search of an article, and then to fail to lift up the tray within the trunk." In other words, one must be prudent. Prudent principles existed as regards thoughtful treatments. The main and subsidiary principles were summarized succinctly by Billroth.²⁵

I consider it to be the duty of a surgeon, under certain circumstances, to deceive his patient as to the incurability of their disease whenever he considers an operation unadvisable, or when he declines to undertake it. The surgeon, when he cannot remove, ought to relieve the sufferings of his patient, both psychically and physically. Few persons possess that peace of mind, resignation, or strength of character, call it what you will, necessary to enjoy life quietly with the knowledge that they are the subjects of a fatal disease. Patients, outwardly calm, seldom really thank you for too plain a confirmation of what they secretly suspect. As a surgeon you will often be in difficulties in this respect, and each separate case must be left to your personal good sense, your knowledge of mankind, and your own good feeling.

Feeling for the patient truly comes first. This should happen even if authoritative opinion has to be questioned. On this account, Norford⁶ went so far as to call it "criminal modesty" if one allows the weight of authoritative opinion to "hinder a proper search into the truth of such circumstances, as might be prejudicial to mankind." "Certainly," he asserted, "no improvement can be made, in any art or science, where a rational liberty of enquiry is denied." Can the best options be found? The answer is yes, especially if, as Freund²⁰ contended, there is actually "warrantable practice" which would ensure that a doctor would not be condemned "both in this life and the next." Also condemned by Scarpa²⁶ was "harsh and injudicious treatment." As for the views of Thomas,²⁷ what will "render the operation improper" and what "the practitioner may think proper to employ" were noteworthy.

Noteworthy, in this context, is the question of "propriety". Some examples are italicized thus "the propriety of using this remedy;²⁸ "some of the ablest surgeons do still admit the propriety of it in certain abscesses" (Sharp 1861); "propriety of amputating the limb must become the subject of consultation";²⁹ and "propriety or otherwise of ablation of cancer".³⁰ Incidentally, when the patient is pregnant, the treatment option is "to consider the safety both of the mother and the child".⁹ Consequently, the question of propriety had connotations which were patently wide.

Wide and humane were the personal interactions involved in family practice. As regards a happy household, Knapp²⁴ wrote: "I was consulted because the family was anxious for an operation." And, what of the children? Concerning a child who died at the age of 4 years, Balfour³¹ was informative: "Occasionally, during her illness, she was even cheerful, and would sing and play with the rest of the family." Regarding a girl aged nine years, Bramwell³² reported that she "found out for herself that the application of cold to the head relieved the headache. Her mother stated that the patient used to stand for half an hour at a time with her head under the cold tap." As regards a boy of twelve, Church³³ wrote: "he complained of feeling sick, and was obviously so much more uncomfortable on the days on which salicylate of soda was given, that I gave up using it."

It is suffering that is the bane of patients. The old authors described it in such harrowing terms as "a most wretched state of suffering";³⁴

"the last degree of torture";³⁵ "a most vehement pain (which) day and night most cruelly tormented the patient";³⁶ "suffering from intense pain";³⁷ "sinking most painfully";³⁸ "state of inexpressible pain";³⁹ and, as Curgenven⁴⁰ lamented, "great suffering." Suffering was well characterized by Laurence⁴¹ in his surgical book: Of the highly expressive terms in which patients give utterances to their feelings, I may cite such words from my note books as pain which "drives in like a dart," - "as if a person were running the point of a knife into it, and then drew it back again" - pain of a "plunging nature, as if a bundle of forks were driven into the part." Such are among the fanciful, but striking similes that they adopt to convey an adequate idea of their sufferings.

Sufferings, we should note, were felt by those who were treating the sufferers! For instance, as Coupland⁴² couched it, the way a woman "died suffocated ... was terrible to witness." In the case of breathing problem, it was described as being "most painful to witness".⁴³ Or, as a Dublin doctor³⁷ put it, "A state more piteous could scarcely be imagined." No wonder that Simon⁴⁴ asked: "how can we not feel that the powerlessness of surgery in relation to cancer is a pain, if not even a reproach, to all of us?" Clearly, humane attitudes were to the medical masters of yester years of candid concern.

Concern was manifested through the compassionate care of ill persons. Consider, for instance, the ordinary issue of examining ill patients. Even the seemingly ordinary practice of applying the stethoscope on the chest, i.e., auscultation, was not persisted with because the patient's "feebleness prevented his being accurately auscultated".⁴⁵ And so it was in another patient "in consequence of the tenderness of the surface of the chest".⁴⁶ Likewise, one infant "was too feeble to allow any thorough examination";⁴⁷ while one adult was so poorly that "even the weight of the bed-clothes is unbearable".⁴⁸ Similarly, in using a syringe to remove excessive fluid from the chest of a teenager, we can perceive⁴⁹ thoughtfulness: "Towards the end of the examination the patient complained of pain in the side, coughed a little, and became so extremely faint that the operation was at once stopped."

Stopped also, when it became necessary, was the mere application on the chest of the diagnostic measure called percussion. Thus, a woman complained, when percussion was used, that "she could not endure it, and declared she should die if it was repeated".⁵⁰ Of course, it was not repeated. Little wonder that there has long been a maxim in medicine, namely, "in every inquiry which we make as physicians, practical usefulness to sick men ought to be our chief aim".⁵¹ In this connection, Carswell's⁵² priority was that "what is of great importance is to alleviate the sufferings and prolong the life of the patient." Moreover, as Fenwick² saw it, "You must try to relieve symptoms and to support the strength of the patient." On the whole, the relief of distressing symptoms was harped on.⁵³⁻⁵⁵ Consequently, "a greater prospect of alleviating the extreme sufferings of our patients," according to Sims (1833), rests squarely on advancing knowledge.

Knowledge surely deserved to be advanced. To be exemplified is the autopsy. Pray. Of what good is the postmortem examination to humanity? Virchow,⁵⁶ the father of cellular pathology, opined thus: "If he is sufficiently versed in the methods of such examination and has the time to devote to it, no one is better qualified for this task than the practitioner himself; otherwise he should call in the aid of a reliable and careful morbid anatomist." To be specific, in a woman who died unexpectedly, the reason for resorting to such an examination was clearly adduced thus: "A termination so sudden and unlooked for, led to a careful examination of the body after death".⁸ As in our own

time, relations often felt uneasy about granting permission for it to be performed.⁵⁷ In the words of Travers,¹⁹ “The post mortem examination to my great disappointment was peremptorily refused.” According to Sir Cooper,⁵⁷ “The idea of opening the body of a deceased friend is always repugnant to their feelings, and not necessary in their judgement.” As Morris⁵⁸ reported regarding a middle aged woman, most parts were not examined owing to “the objection of friends.” The story was much the same as when told by Salter⁵⁹: The friends, who narrowly watched the examination, would not allow the removal of the diseased parts or any portion of them, so that no more complete dissection or careful drawing of them could be made.

Made of mean streaks, unlike humane doctors, were the quacks. As Norford² expressed it, “the simplest remedy, in the hands of the ignorant, becomes like a sword in a mad-man’s hand.” At a meeting held on 28th April, the President of the Medico-Chirurgical Society mentioned the stage when patients become “ready to impart their confidence to any man who is ignorant and unprincipled enough to promise boldly”.¹⁹ As it was recognized way back by Wiseman,⁷ the quacks “amongst us brag much of their skill” and also promise “great hopes of cure.” In short, earlier, Read⁶⁰ was writing about how they “make a show of learning.” In the same vein, Sir Spencer Wells³⁰ warned that “female galvanic doctors are at work, and others calling themselves electro-homeopaths.” Incidentally, Friend²⁰ exposed quacks who could hold something in their hands or have them in their mouths, while pretending to retrieve them from their victim’s body.

Body of knowledge in the field of human health care has been growing. For example, the well being of others prevented cancer experiments from being carried out on fellow human beings. Thus, as Beatson⁶¹ confessed, “I was very unwilling to do anything of the nature of experiments on my fellow creatures.” Or, as Pearson¹⁷ perceived it, “no man ever had, nor ever will have the unwarrantable temerity, to attempt the solution of this pathological doubt, by a method so repugnant to humanity.”

Humanity is the key word for both practitioner and patient. Thus, look at how a woman, who was on the point of death, showed it to Semon⁶²: “As a matter of personal interest I may mention that Miss L - showed the same marvelous fortitude and entire unselfishness up to the very last, and thanked me personally in writing quarter of an hour before her death.” In like manner, when a case needed the opinion of another consultant, Budd⁶³ applied the Biblical golden rule by saying that, “if he were the patient himself, he would run the risk of an explorative operation.” Operation, whether exploratory or otherwise, brings up the question of fees. In some hospitals in bygone years, a discharged patient may remain a virtual prisoner, until payment is made. Therefore, it is pertinent to learn about a pitiful case involving a villager known to Morgagni.⁵

Undoubtedly, the remedy lies with governments. Alas! The experience of Budd,⁶⁴ who gave the Address on Medicine during the Meeting of the British Medical Association, comes to mind. He said bluntly that Government’s action is apt to be carried out with “vigilance and untiring energy” when it comes to economics but not “when the interests of health only are concerned.”

Conclusion

Concerned with humaneness in cancer surgery were the giants of old. They have been presented here in the form of a gamut of eponymous and other names whose works appeared from 1635 to 1896. Perhaps, it is opportune to mention that, as Frewer & Rothhaar⁶⁵ editorialized recently, “The medical and healthcare communities

stand at the forefront of fundamental challenges.” Yes! These challenges have long needed the humane touch. Indeed, as to the future, Mechanic & Altman⁶⁶ saw it very nicely as the opportunity to encourage innovation in health care delivery.

Acknowledgments

None.

Conflicts of interest

The authors declare there is no conflict of interests.

Funding

None.

References

1. Pijnenburg M. Humane healthcare as a theme for social ethics. *Med Health Care Philos.* 2002;5(3):245–252.
2. Fenwick S. Clinical lectures on some obscure diseases of the abdomen. London, UK: London Hospital; 1889. 207 p.
3. Coote H. Instances of melanosis, with observations. *Lancet.* 1846;48(1196):122–124.
4. le Dran HF. Operations in surgery. Trans by Thomas Gataker, Cultitch, London; 1749. 300 p.
5. Morgagni JB. The seats and causes of diseases investigated by anatomy: in 5 books. London, UK: Lond Millan and Cadell; 1769. 668 p.
6. Norford W. An essay on the general method of treating cancerous tumours. J Noon, London; 1753. 8 p.
7. Wiseman R. Severall chirurgical treatises. Royston, London; 1676:99–113.
8. Stokes W, Daniels WB. A treatise on the diagnosis and treatment of diseases of the chest. In: Hodges, Smith, editors. Part I, Dublin, USA; 1837. 371 p.
9. Bell C. Surgical observations. Longman, London; 1816. 404 p.
10. Stokes W. A treatise on the diagnosis and treatment of diseases of the chest. Hodges, Smith, editors. Part I, Dublin, USA; 1837. 385 p.
11. Brown J. A compleat treatise of preternatural tumours. Lond: Clavel; 1678. 137 p.
12. Bell B. A system of surgery. Edin: Charles Elliot; 1789;11:443,456.
13. Home E. Observations on cancer. Longman, London; 1805.172 p.
14. Bell J. Remarkable cases of malignant (encephaloid) disease, occurring in Nos. 1 and 2 medical wards of the glasgow royal infirmary. *Glas Med J.* 1857;4:415–440.
15. Fagge CH. The principles and practice of medicine. London, UK: Churchill; 1886. 79 p.
16. Lack HL. A contribution to the operative treatment of malignant disease of the larynx with special reference to the danger of cancerous wound infection. *Lancet.* 1896;147(3798):1638–1641.
17. Pearson J. Practical observations on cancerous complaints. London; 1973. 41 p.
18. Earle H. A case of diseased testicle, accompanied with disease of the lungs and brain, and terminating fatally. *Med Chir Trans.* 1816;3:59–384.
19. Travers B. Observations on the local diseases termed malignant. *Med Chir Trans.* 1829;15(1):195–262.

20. Freind J. The history of physick. Part I, Lond: Walthoe; 1728;65:150.
21. Macbride D. A methodical introduction to the theory and practice of physick. In: Strahan, Cadell, editors. 4th edn. London; 1772. 660 p.
22. Gross S. Sarcoma of the long bones based upon a study of one hundred and sixty-five cases. *Am J Med Sci.* 1879;75(155):17–57.
23. Hutchinson J. On the local origin of cancer. *Med Times Gaz.* 1888;92–96.
24. Knapp PC. The pathology, diagnosis and treatment of intracranial growths. In: Rockwell, Churchill, editors. Boston, USA; 1891. 160 p.
25. Billroth T. Lectures on surgical pathology and therapeutics. London: New Sydenham Society; 1878. 572 p.
26. Scarpa A. A treatise on the principal diseases of the eye. London, UK: Cadell and Davies; 1818. 513 p.
27. Thomas R. The modern practice of physick. London, UK: Murray and Highely; 1801;101:271.
28. Seymour EJ. Cases of tumours in the abdomen arising from organic disease of the stomach with remarks. *Med-Chir Trans.* 1828;14:222–250.
29. Arnott H. On the therapeutic importance of recent views of the nature and structure of cancer. *St Thomas's Hosp Rep.* 1871:2103–122.
30. Well S. The Morton lecture on cancer and cancerous diseases. *Br Med J.* 1888;2(1458):1265–1269.
31. Balfour T. Case of encephaloid cancer of the right kidney and of the lung, simulating ascites and terminating fatally. *Edin Med J.* 1855;1:149–122.
32. Bramwell B. Intracranial tumours. In: Young Pentland, editor. 1888. 251 p.
33. Church WS. A case of intra-thoracic tumour. *St Bart's Hosp Rep.* 1878;14:241–254.
34. Muys J. A rational practice of chyrurgery. In: Sam Crouch, editor. London, UK; 1686. 161 p.
35. Monro A. The morbid anatomy of the human gullet, stomach and intestines. In: Archibald Constable, editor. 1811. 339 p.
36. Hodgkin T. On some morbid appearances of the absorbent glands and spleen. *Med Chir Trans.* 1832;17:68–114.
37. Graves RJ. Observations on the treatment of various diseases. *Dub J Med Chem Sci.* 1834;4:309–328.
38. Bright R. Observations on the situation and structure of malignant diseases of the liver. *Guy's Hosp Rep.* 1836;1:638–648.
39. Walshe WH. The nature and treatment of cancer. In: Taylor, Walton, editors. London, UK; 1846. 285 p.
40. Curgenvén JB. Cancer of the ovaries and stomach. *Trans Path Soc Lond.* 1862;13:172.
41. Laurence JZ. Diagnosis of surgical cancer. Churchill, London, UK; 1855. 55 p.
42. Coupland S. Cancer of both breasts and ovaries. *Trans Path Soc London, UK;* 1876;27:259–264.
43. Milton JL. On scirrhus of the male breast. *Med Chir Trans.* 1857;40:141–156.
44. Simon J. An address on some points of science and practice concerning cancer. *Br Med J.* 1878;1(894):219–224.
45. Paget J. Account of a growth of cartilage in a testicle and its lymphatics and in other parts. *Med Chir Trans.* 1855;38:260–269.
46. Neligan JM. Case of adipose sarcomatous tumour in the anterior mediastinum, with remarks. *Edin Med Surg J.* 1840;53:372–376.
47. Morgan JH. Sarcoma of the scapula in an infant. *Trans Path Soc Lond.* 1878;30:399–403.
48. Mackenzie JC. Melanotic sarcoma very widely disseminated. *Trans Path Soc Lond.* 1891;42:321–329.
49. West S. Three cases of tumour of the lung. *Trans Path Soc Lond.* 1884;35:91–92.
50. Moxon W. Encephaloid cancer of the heart and scirrhus cancer of the thyroid gland. *Trans Path Soc Lond.* 1867;18:38–41.
51. Moore N. Distribution and duration of visceral new growths. *Lancet.* 1889;2:415–420.
52. Carswell R Scirrhus. The cyclopaedia of practical medicine In: Forbes J, Tweedie A, Conolly J, editors. Sherwood, Gilbert, and Piper, London; 1834. 676 p.
53. Mackintosh J. Principles of pathology and practice of physick Vol 11. Philadelphia: Key and Biddle; 1836. 354 p.
54. Alison WP. Outlines of pathology and practice of medicine Part III. Edin: Blackwood; 1849. 528 p.
55. Snow H. Is cancer hereditary? *Br Med J.* 1885;2:690–692.
56. Anonymous. Professor Virchow on cancer. *Lancet.* 1888;1:145–146.
57. Cooper A. Observations on the structure and diseases of the testis. In: Long Rees, editor. London; 1830. 146 p.
58. Morris H. Pulsating tumours of the left parietal bone, associated with great hypertrophy of the heart. *Trans Path Soc Lond.* 1880;31:259–272.
59. Salter H. Clinical lectures on diseases of the chest. *Lancet.* 1868;2:2–4.
60. Read A. The chirurgicall lectures of tumors and ulcers. Francis Constable, London, UK; 1635. 25 p.
61. Beatson GT. On the treatment of inoperable cases of carcinoma of the mamma: suggestions for a new method of treatment, with illustrative cases. *Lancet.* 1896;2:104–107.
62. Semon F. A case of malignant disease of the thyroid gland with most Unusual Course. *Med-Chir Trans.* 1893;76:375–390.
63. Budd W. The address in medicine. *Brit Med J.* 1863;1:141–150.
64. Watson T. Lectures on the principles and practice of physick. John Parker London; 1843;1:213.
65. Frewer A, Rothhaar M. Medicine human rights and ethics: paths to universal rights. *Med Health Care Phil.* 2010;13(3):247–249.
66. Mechanic R, Altman S. Medicare's opportunity to encourage innovation in health care delivery. *N Engl J Med.* 2010;362(9):772–774.