
FROM THE EDITOR

One hundred meters

To walk 100 meters at 4 kilometers per hour (an average walking pace) takes about 1.5 minutes. What would prevent an oncologist investing this brief time in visiting a patient in the next building? It is not that oncologists as a group are uncaring. I can think of too many examples where the opposite is true.

Was he too busy? Was he burned out? Did he feel guilty at having failed to control the disease and save a life? Finally the penny dropped and the obvious association was made: The patients thus neglected were those that were dying. This may not be a surprise, but it is surprising. The oncologist was repelled by death. Not visiting a dying patient and family whom one has treated for months is unprofessional, to say the least. It is also not decent. So why would otherwise pleasant professionals behave in this way?

In previous writings and musings I have emphasized Ernest Becker's concept of the fear of death as the motivating force for such errant behaviors (Becker, 1972). The fear (or "terror" as Becker prefers) manifests in many guises. The oncologist may, through a mild unconscious discomfort, be aware of his avoidance behavior. However, the fundamental cause, the fear of death, remains opaque to his awareness.

I recently pulled out from my library a book I bought years ago but that had remained unread. Robert A. Burt (2002), a professor of law at Yale University, published *Death Is That Man Taking Names*. The subtitle describes it as a study at the "intersections of American medicine, law, and culture." Burt suggests a fundamental drive other than fear of death to explain aberrant behavior by the medical profession in confronting very sick patients.

This suggestion came very much to life during a recent oncology ward round. We entered the room of a man who was sedated and dying. We had gotten

halfway in when the case was presented as a thumbnail sketch, whereupon we made a dismissive about-face and exited. I thought to myself, OK, the oncologist was only filling in and did not feel it appropriate to intervene in a private peaceful process. However what struck me like a bolt was the facial expression of the oncologist as we were leaving. It was not neutral, nor sad, nor fearful. It was one of disgust. Death was disgusting, even abhorrent. Hence the connection to Burt.

I quote Burt (2002, p. 12): "In our Western cultural tradition, death is not viewed simply as a fearful event; there is an aura of wrongfulness, of intrinsic immorality, attached to the very idea of death." The conjunction of a sense of wrong and immorality with a highly emotive situation such as death produces disgust or abhorrence.

Here is another piece of evidence supporting this observation. As I was puzzling through the first drafts of this article I was asked to consult on an educated middle-class lady in her early 70s who was just diagnosed with her third cancer. I was probing her coping mechanisms, when she piped up and said: "I often wonder what sin, what I have done wrong to deserve these illnesses." Seeking an explanation for why or how things go wrong is healthy curiosity. Blaming oneself (against scientific knowledge) or feeling guilty suggests the wagging finger of morality.

A sense of "immorality" or "wrongfulness" of death is a different dimension from that of fear. Burt finds support for this idea by interweaving cultural and psychoanalytical concepts.

Burt traces one of the sources of Western culture to Genesis and the Garden of Eden. Here, he suggests, death was introduced to the world as a punishment for eating the forbidden fruit. One should note, however, that some Biblical scholars dispute that Adam and Eve were immortal prior to eating the fruit. There was another tree in the Garden of Eden that was forbidden to them, the Tree of Eternal Life. Therefore later in Genesis, God explains His reasons for expelling them from Eden: "And the Lord said: Man has become like one of us, having knowledge of good and evil; and now if he puts out his hand

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and takes of the fruit of the Tree of Eternal Life, he will go on living for ever" (Gen. 3:22). Although the case of Adam and Eve *v.* God is still one of crime and punishment, it is likely that the punishment was the death sentence, not death itself. "Death" in capital punishment is "merely" bringing the anointed hour forward.

Burt identifies two psychoanalytic forces at play, neither of which, he acknowledges, entirely explains the wrongfulness we feel about death. The first point was made by Freud and is best summed up in Freud's ironic observation that "it is impossible to imagine our own death [because] whenever we attempt to do so we can perceive that we are in fact still present as spectators" (Burt, 2002, p. 8). That is, deep down we see ourselves as immortal, even though we are logically aware that all humans die. This inexplicability, or illogical syllogism, pushes us to find an explanation and, in the process, blame something or someone, in short, to find a scapegoat.*

The second psychological mechanism refers to the developmental task of forging our own and unique identity when we separate from parents and society. Burt (2002, p. 10) calls it "a combative wrenching." Later, when we are faced with a fatal illness, we become aware that death will destroy this hard-won and precious self. Death thus becomes the enemy and an evil.

Just as fear of death is masked day to day, so is the disgust of death. However, at a mortal moment the wrongfulness is unmasked and, as Burt suggests, we see death as the adversary in an emotional and moral sense.

It is neither appropriate nor possible to legislate that doctors behave in a certain way. I think communication training can influence behavior, but most evidence points to temporary change at best (Butow et al., 2008). What is more practical is to build into the workplace a structure that forces interdisciplinary care. Such structures may include clinical meetings where case discussions are led by an experienced clinician to create an atmosphere free of judgment and filled with camaraderie. The core disciplines of oncology, social work, nursing, psychooncology, and palliative care should participate. I have seen this function, and it is both productive and fun. In the case of the doctor being frightened of or disgusted by the dying patient, support is seamlessly though purposively provided.

Modern oncologic care is not for the sole practitioner.

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*Lev. 16:21–22. The concept of a "scapegoat" comes from the ritual on the Day of Atonement, when Aaron the High Priest symbolically transferred the sins of the community onto a goat who was sent into the wilderness to die as expiation, another connection between death and wrongfulness.