

Dying Well!—Issues For The Living?*

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Hospice and Palliative Care is a relatively new speciality in Medical Practice and is based on the premise that the family unit, not exclusively the patient, is the focus of care. This paper attempts to outline the development of Hospice and Palliative Care over the centuries and explores the relationship of current practice as the art of medicine rather than science. Through the narration and discussion of a family interaction, the paper draws a parallel to situations common in Family Therapy and poses the need for teamwork and a multidisciplinary approach in Hospice and Palliative Care and in Family Therapy.

INTRODUCTION

It is often stated that we are living in a death denying society. It is one of the dicta of the Hospice and Palliative Care movement and is used to make those of us who work in the area of caring for the dying comfortable in continuing on. Like most pieces of dogma, it is open to question. Any watching of the evening news and a glance through the newspapers on any day will reveal a society fascinated by death and the manner of dying. However, that which fascinates us also holds us in fear, and I believe this dilemma makes it difficult for us as individuals or as a society to deal with dying and death in a consistent manner.

As a society we have become unfamiliar with death as a part of our day to day existence. Death is no longer at the centre of life as the graveyard was at the centre of the town. It is therefore something which happens to others; 'all men think all men are mortal but themselves' (McManners, 1987) and we have, as a society, attempted to transfer the immortality of youth to old age. We seem no longer to accept death as a natural process over which we have no control and indeed, if someone dies, then someone must be at fault (Buckman, 1993).

A person's death is not a singular event. In Hemingway's *For Whom the Bell Tolls* we learn that 'any man's death diminishes me'. We need to remember that dying, like childbirth, involves more than the individual, with often many sharing experiences of suffering and loss. For families the death is a time of very mixed feelings: of loss and despair; of understanding and gentleness; of reflection and laughter; of grief and joy; and of reforming and destruction. The majority of families seem to find the resources within themselves to cope

with the loss and rebuilding necessary in the face of death. Some, however get stuck at some point in the process and may require help, but above all, understanding from people who can stand with them in the face of death.

Hospice and Palliative Care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of hospice and palliative care is the achievement of the best quality of life for patients and their families. Many aspects of hospice and palliative care are also applicable earlier in the course of the illness, in conjunction with anti-cancer treatment.

Hospice and Palliative Care:

- affirms life and regards dying as a normal process;
- neither hastens nor postpones death;
- provides relief from pain and other distressing symptoms;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement.

(World Health Organisation, 1990)

The word 'palliative' is derived from the Latin *pallium*, a cloak. The term Palliative Care has been used in Australia and Canada as a deliberate attempt to set aside the religious connotation of the term Hospice which is used primarily in the United Kingdom. In Australia there has been acceptance of both terms to the extent that 'Hospice' and 'Palliative Care' are used interchangeably. When I first met the word 'palliative' it was explained to me that the meaning was that of cloaking the symptoms of disease and hiding things from view. However, having seen my nursing colleagues at work, I would suggest the proper meaning is to wrap or envelop and pro-

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vide warmth and protection for the individuals and their families.

THE ORIGINS OF HOSPICE AND PALLIATIVE CARE

The original Hospices were the *hospes* (guest houses) of the monasteries and cathedrals situated along the pilgrimage routes of Europe during the middle ages. They were set up to meet the needs of travellers who would arrive weary and sick from their journey, often having been beset by robbers and brigands. The monks and nuns would provide food, shelter, medicines and religious comfort to meet their physical and spiritual needs. Some of the travellers were unable to continue their journey and the monks and nuns continued to care for them till they died, utilising medicines and plainsong to ensure their comfort. (Saunders and Sykes, 1993: 4-7)

However, even though all the early hospices had to offer was palliation, the recoveries of some people were hailed as cures, often miraculous, and individuals seeking cures to various ailments travelled from far and wide to get treatment there. Thus Hospitals evolved which were 'for the ayde and comferte of the poore, syke, blynde, aged and impotent persons ... tyll they be cured and holpen of theyre dyseases and syknesse' (Dunlop and Hockley, 1990: 3). With the expectation of cure came an attitude change of the medical attendants to the point that as early as 1544, surgeons were employed 'to see if patients were curable or not, so that none should be admitted who were incurable, none rejected who were curable' (Dunlop and Hockley, 1990: 3).

In some ways it was probably just as well that people with incurable illnesses were excluded from the hospitals of the Reformation and beyond. Problems of overcrowding, high incidence of nosocomial infections, 'septic' surgical techniques and a general lack of sanitation resulted in unacceptably high levels of morbidity and mortality. Hospitalisation was looked on as inherently dangerous and the majority of the population, where they were able, preferred to remain in, and to nurse their relatives at, home. Prior to 1900, the majority of deaths (approximately 90%) occurred at home.

Societal Changes

The social and political upheavals accompanying the French Revolution and the Industrial Revolutions in Britain and progressively in the rest of the developed world saw dramatic shifts in population from the rural areas to the cities, a change in living standards, arguably initially for the worse. Overcrowding and poor sanitation led to an increased incidence of infectious disease, particularly in lower socioeconomic groups, high levels of morbidity and mortality. The average age of death actually decreased for some groups and the cause of death was often infection or injury. Diseases normally associated with ageing, particularly cancer, were rare, and the disease most likely to cause a lingering death

was tuberculosis. Otherwise death was usually a relatively swift event which was often managed in the home (Corr, 1993).

It is a poor reflection on society to realise that the initial attempts by people such as Wilberforce and Snow to improve the health of people gained momentum primarily because the cost of labour was being driven up through 'wastage' as a result of sickness. It was only then that the great engineering undertakings (both civil and social) commenced in earnest (Sanders, 1991). Improved sanitation, the provision of reliable supplies of potable water, improved transport and supply of food as well as the progressive eradication of insect vector illnesses led to a dramatic and rapid improvement in the health of the general population with a noticeable change in survival and mortality figures. A drop in infant mortality and increased longevity saw a change to the pattern of illness and cause of death and an upsurge in the number of deaths through cardiovascular disease and cancers (Lawson, 1993).

The mid 1800s also saw a resurgence of medicine, particularly surgery. Aseptic technique as advocated by Semmelweis and Lister, though slow to take hold, reduced operative mortality and the development of anaesthetics and a better knowledge of anatomy and physiology saw a revisiting of hospitals as a place of 'cure' (Willis, 1990). It also resulted in a change in the manner of dying as life was prolonged and people became more and more dependent on families for support. This has become even more pronounced now with the advent of chemotherapeutic and radiation therapy which have the capacity to prolong life and modify the dying process (Corr, 1993: 31).

Medicine as a Science

In the twentieth century, science and the ideal of scientific rationality have played an important part in medical education and the care of patients and are now central to the way in which doctors and patients view the profession. Scientific advances have given society an almost unassailable confidence in medical efficacy. However, epidemiologists and historians of medicine have shown that improved health and lengthened life are more a result of a productive agriculture, pure water supplies, improved hygiene, and population control. The incidence of heart disease in Australia has been lowered not by the ingenious techniques of cardiac surgery but by the sustained alteration of dietary and exercise habits (Lawson, 1993: 3-20).

As a result of such progress, medicine has been unthinkingly assimilated to other intellectual advances of the twentieth century, and physicians as well as patients have been led to believe that medicine is itself a science. The evidence for this appears strong. Doctors have spent years learning the minutiae of human biology. They conduct scientific research. They use intricate machines designed on scientific principles to detect and treat disease and physical malfunction. They wear white coats as a sign of their professional objectivity.

Doctors, like the oracles of old, are accorded the power to predict the future through their (often wrong) prognostications and are expected to be rational and fearless in the presence of a patient's impending death. In a culture that shrinks from death, doctors have been given the mantle of special knowledge and 'science' serves as the framework for this knowledge (Hunter, 1991).

However, no matter how scientific the practice of medicine has become, medicine is not a science as science is commonly understood.

Science is based on a belief that it and its methods are value free—anything that happens in nature is neither good nor bad, it simply *is*. On the other hand, medicine has a tradition in which a hierarchy of values—the patient comes first, doctors must above all do no harm, the good of the patient is intended—is firmly established (Cassell, 1991:18).

Science is important to the practice of medicine as it allows for a greater understanding of the structural processes of diseases in an anatomical, biochemical and physiological framework, but it has little to offer in the management of a sick patient whose life has been disrupted by the burden of illness and who is in need of understanding and support (Kleinman, 1988). Such issues are relegated to the 'art' of medicine or to individual judgment.

Medicine and Suffering

Medical commentators such as Cassell, Kleinman and Hunter have outlined the shortcomings of medical science and its inability to deal with the individual needs of patients, particularly those with chronic illnesses. They suggest that the development of technology, intended to reduce uncertainty in diagnosis, has made the uncertainty less likely to be acknowledged by doctors or tolerated by the public. The relationships between patients and doctors have developed a level of 'them and us' conflicts where the focus is on the diagnosis of the disease rather than the care of the person who is ill.

For individuals who are dying, a medical system which is programmed to diagnose and treat without attention to the needs of the whole person can in effect add to the suffering of patients and their families and friends (Cassell, 1991: 241). In the book of the ABC television series *The Trouble with Medicine* Konner cites instances where individuals with advanced cancer 'try to die' but are 'saved' by the application of scientific medicine even though the outcome is inevitable. A relative of an 82 year-old man with advanced pancreatic cancer who is being ventilated as part of the management of a pneumonia is very perceptive:

Doctors have a lot of trouble with [not treating], because they're doctors—they're supposed to cure people. And it's very difficult for a lot of [doctors] to say, 'Gee, I can't.' I think the medical profession needs to know that it's okay to die (Konner, 1993).

Doctors also need to be aware of their potential to add to the burden of patients and their families. Eric

Cassell, an American oncologist, in a seminal paper in the *New England Journal of Medicine* reminds us that:

Suffering is experienced by persons, not merely by bodies and has its source in challenges that threaten the intactness of the person as a complex social and physiological entity. Suffering can include physical pain but is by no means limited to it. The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians' failure to understand the nature of suffering can result in medical intervention that [though technically adequate] not only fails to relieve suffering but becomes a source of suffering itself (Cassell, 1982: 644).

Suffering and the Individual

It is also important to remember that an individual's suffering does not occur in a vacuum. In 'The Death of Ivan Ilyich', Leo Tolstoy powerfully illustrates the physical and psychological pathway, both tortuous and painful, which all of us may need to travel (Tolstoy, 1995). This profound work of literature is one of the greatest explorations of life and death ever written. Ivan Ilyich, an ordinary man living in late 19th century Russia, has a family, is educated, and serves as a judge. He is also faced with an incurable disease. He consistently resists asking for help, believing that by doing so, he is resisting his disease. But he eventually comes to understand that his family and friends are there to help him. Only then can he say the words, 'Please come here and help me'.

The development of hospice and palliative care has brought with it the recognition that dying is a process, not a symptom; and physical comfort is of itself insufficient to meet the needs of the dying individual and his or her family. Palliative care has the stated philosophy that the patient and family is the unit of care and the major care givers are seen as the family, friends, nurses, chaplains, volunteers as well as the doctors. Patient directed care is seen as a goal of most hospice and palliative care services and units (Biswas, 1993). Palliative care has also brought forward the recognition that death is not a failure of care but a process that can, although painful, allow for growth in individuals and relationships which can indeed be enriching and achieve true healing. The patient, family and carers may discover they have a range of inner resources never before imagined (Saunders and Sykes, 1993: 6–12).

The scientist doctor has long eschewed individual case histories and reporting as anecdotal and believes these have no place in the 'modern' practice of medicine. Palliative care is based on the premise that each person presents individual needs and whilst they may possess similar labels, their care is essentially a 'one off', reflecting the uniqueness of the human individual. Scientific rigour is not able to accommodate spiritual issues and has difficulty in dealing with the dynamic processes of families.

The Patient and the Family as the Unit of Care

One of the dicta of palliative care is that the patient and the family is the unit of care (World Health Organisation, 1986). Most often the presenting issue involves the individual with the disease. The family issues tend to be related to the disease process and how the family unit is coping with the progressive deterioration and eventual demise of the individual. Palliative care practitioners aim to work in partnership with the patient and the family to share information and to develop joint decision-making processes (Saunders and Sykes, 1993: 176–182).

Developing the partnership can occasionally be most challenging and can be a tenuous process. We doctors and nurses come to the process with almost a naive belief that we will be welcomed with enthusiasm. Carer impotence affronts our egos and when our advances are rebuffed we can ourselves feel responsible and lose our effectiveness as helpers (Cade, 1982: 23–26). One of our responses is to deflect the responsibility away from ourselves through labelling the family as a problem family, thus absolving us of the failure. It may be that we do not have the necessary resources to meet the needs of every patient and their family.

Certainly the ongoing practice of Palliative care affirms that no one individual has the necessary resources to meet all needs; multidisciplinary teams and team work are essential tools in Palliative care (Woodruff, 1993). The following case history is one in which the family and the carers had become enmeshed in a seemingly endless, escalating struggle where increasing input of effort seemed to result in greater entrenchment of the problem. The nexus was broken through the declaration of carer impotence and the re-engagement of the family as equals.

In presenting this case history I gratefully acknowledge the contribution and support of my colleagues and I also thank the family for allowing me to see things with different eyes.

CASE DISCUSSION

Robert was a 50 year old man with a terminal progressive disease who had been referred to me by his GP in January 1995. The method of referral was by way of an invitation to lunch by the General Practitioner who wanted to discuss the case with me in the hope that I could provide him (the GP) with some support in managing the situation.

The GP outlined a history of a man who had been diagnosed with his illness eighteen months previously, following a period of uncertainty for about six months before a definite diagnosis was made in the Teaching Hospital. Robert was a master mechanic who ran his own business and at the time of diagnosis was given a definite prognosis of six months. Robert had sold up his business and he and his wife, Susan, had been waiting for him to die (without success) for the past year and according to the GP the 'novelty was wearing thin'.

I was told that Robert had had a liking for the drink

and although always in employment had been under the Drug and Alcohol Services umbrella off and on for many years. Susan had been attending Al Anon meetings for years and was receiving therapy for co-dependency. The GP told me that they had lived separate lives for the twenty or so years they had been married and the period of Robert's illness was the longest time they had been continuously together since they were married.

Robert was getting to the stage where weakness was preventing him from negotiating stairs within the house and was becoming progressively short of breath with occasional episodes of panic in the evenings due to sputum trapping. He was reluctant to take any medications because of the fear that his son, who was on bail because of drug offences, might misappropriate them and also, it was surmised, because of his fear of the medications losing their efficacy before things got worse. He had also been progressively losing weight despite the use of steroids.

The GP's main source of frustration seemed to be with Susan who, he thought, seemed to be actively sabotaging attempts at providing care. Community Health nurses had been called in, with Susan's consent, but they found they were excluded from providing care, were criticised for splashing water on the bathroom floor, and generally were made to feel unwelcome. The same seemed to happen with the visiting physiotherapist and speech therapist. The only professional who had succeeded in getting through effectively was the Palliative care social worker who had taken on an advocacy role for Susan as well as looking to meet Robert's needs.

The GP and I organised to do a joint home visit. However, as doctors are wont to be, we were twenty minutes late. We were met at the front door by Susan who immediately castigated us for delaying her when she wanted to go out. I offered to come back at a more convenient time, but she said we could stay. She told me that no one understood what problems she was going through and how no one had offered any help at all until the social worker had begun to have contact.

We acknowledged her distress but asked if we could see Robert so that I could gain an overall impression as to the clinical situation. Robert was lying in bed. He was obviously wasted and was unable to get up without help. There was marked involvement of all muscle groups. His breathing was laboured but his speech was well preserved. He complained of spasm type pain in his legs and back together with weakness and decreasing mobility. His primary concern however was the recent development of respiratory panic attacks the last few nights. When Susan went to get him a drink of water he whispered to us that she was killing him by preventing the nurses from giving him care. He also felt his wife was punishing him for his past behaviour, but he said he gave as good as he got.

Our suggestions of admission to the Palliative Care Unit for a period of evaluation were politely refused, as were offers of diazepam, morphine etc. for the panic attacks and dyspnoea. He said he didn't want to take

any drugs. He had seen what they had done to his son. His mother had been addicted to benzodiazepines in the past, so he was scared this could happen to him. He agreed to try some nebulised morphine and asked that I come back and see him the following week. I organised a time and went with the GP to talk with Susan.

Susan's version of events was quite different to Robert's. She acknowledged he was ill but said that he was insisting on her being the sole carer and that no one understood what she was going through. She was particularly angry at the previous physician for giving such a definite prognosis which had lost its currency twelve months ago. She demanded of me an equally definite prognosis and expressed her displeasure at me when I was deliberately vague and suggested that Robert had weeks, possibly months, of life left. She expressed doubt that she could cope if it went on much longer.

She detailed her life with Robert as one where they had survived as a couple essentially by living non-intersecting lives. He drank and was abusive, she looked after the children and they had a holiday house where they would spend alternate weekends and separate holidays. This was the first time in their life that they had spent so much time together and Susan said they were destroying each other. She felt really sorry for him and wanted to do everything for him but she felt angry that he was not allowing others in to help.

Robert joined us at this stage and we talked about help. He said that he was happy to have nurses come in to help him but that Susan had stopped them from coming because they made a mess in the bathroom with the shower. After a further, fairly heated discussion, they agreed to my suggestion for re-involving the community nurses and agreed to a trial of care for a two week period. I again raised the issue of a respite or assessment admission to the Palliative Care Unit. Both Robert and Susan put up arguments against it, so I let the matter lie on the table.

When I saw Robert a week later I found him more accepting of the idea of a respite admission but Susan seemed more entrenched in the idea of Robert remaining at home. She accused me of trying to take him away from her. She said she was able to care for him and had demonstrated it by doing all the care for Robert before the nurses had arrived each morning and she had sent the nurses away. She said she and her daughter could care for Robert and she didn't need any help at all. I asked him what he wanted at this stage and he said he would prefer to stay at home if that was what Susan wanted. I asked if they were happy with my continued involvement and both he and Susan said they were happy for me to continue to visit, however the nurses were to be put on hold. The social worker's visiting rights were reaffirmed.

The Admission

The social worker and I conferred often and at length about the situation but could only come up with the strategy of trying to hang in there and hoping to get an

opportunity to intervene. As fate would have it, Robert developed an upper respiratory tract infection and had increasing respiratory distress. Both he and Susan panicked and he was admitted to the Palliative Care Unit. Physical interventions with some non-sedating histamines, a little morphine and some oxygen settled Robert; he happily adjusted to the Unit and refused to go home.

It is fair to say that Susan was not impressed and accused me and the staff of the Unit of turning Robert against her. She threatened to go to the media and expose us. It worried the staff on the Unit that we had become embroiled in this situation and it resulted in a number of informal discussions amongst the staff about what to do. It was decided to call a formal meeting with Robert and Susan, the GP, other family members, the staff on the unit, myself and the social worker with the intention of clearing the air.

The Family Meeting

In preparing for the meeting the social worker, the CNC of the Unit and myself met to formulate a strategy. We felt there was no point in trying to lay blame on any one and decided that we would try to be directive if any recriminations were forthcoming. We all felt that both Susan and Robert were traumatised by their experiences and that, whilst Robert had the losses of the disease, Susan had to make the emotional readjustments to the change in relationship and her loss of her previous family role and lifestyle. We resolved that I would open the meeting with a summary of the clinical situation and give an outline of our understanding of the stresses that such a disease in one partner can place on a marriage, however strong. I was not to suggest that we perceived any problems in their relationship, rather that we were impressed by the strong protective features shown by both Susan (in wanting to do everything possible for Robert at home) and Robert (in wanting to take the burden off Susan by remaining in hospital). I was also to suggest that we didn't know what to do next and we needed their help.

The meeting was duly constituted and I led off with the prepared statement. It was probably no surprise to anyone present that Robert and Susan initially disagreed with the suggestion that each was protecting the other, however, it was pleasing that they joined forces in outlining the strengths and good times they had in their relationship. They moved rapidly towards the conclusion that they had never found it easy to live together during their married life, and that the illness had created an artificial situation in which they both felt trapped. The admission to hospital provided a necessary circuit breaker and allowed Robert the security he needed to say he wanted out. Susan admitted that since he had been in hospital she had felt more relaxed and freed up to do things for herself. Susan acknowledged that it was hard for us not being able to have all the answers to everyone's problems.

It was decided that Robert would undergo an ACAT

assessment for nursing home placement but that he would go home with community nurse support in the interim. It would be misleading to suggest that all went smoothly thereafter. We had to repeat the meeting format once more at home prior to Robert going into the nursing home; Susan continued with her episodes of anger and Robert continued his gentle provocation from the bed, effectively pulling whatever strings came within reach. He died comfortably in the nursing home a fortnight after admission, with Susan and his daughter present.

On Robert's death, Susan was very distraught and openly expressed her anger against me, the previous doctors, the nursing home and especially Robert for leaving her. Thankfully, after this initial catharsis, she was able to put things behind her, resume her employment and, when last seen, was able to reflect on the process with appropriate sadness tinged with a wry humour. She acknowledged she gave us all a hard time, but thought it was good for us not to always have predictable experiences.

DISCUSSION

The patterns of relationship and behaviour with which a couple presents are manifestations of their construction of reality. This relationship is a powerful force for maintaining a sense of reality for the couple within society. Mutual beliefs are more intense and rigorously protect each member of the partnership from alternatives which threaten to challenge couple integrity (Durrant, 1984). Attempts to alter this structure are threats to the reality base of the couple and have the potential to mobilise the processes which serve to unite the couple against the outside world (Minuchin, 1974: 54-57).

This case history presents a family situation which could well be labelled dysfunctional and indeed, the 'co-dependent' and 'alcoholic' labels were well and truly to the fore in the initial assessment. The initial attempts to provide support to the family were rejected because they threatened the stability of the family unit and solidified the pre-existing positions, blocking any possibility for change. The request, 'Please come here and help me' is met with a deadlock which frustrates both parties to the therapeutic alliance. Thus the GP was thrust into a position of 'therapeutic nihilism' whilst the social worker who started to work with both parties gained acceptance.

Andolfi asserted that:

The major disease from which most therapists suffer is their obsession with being helpful. Although a therapist so handicapped may be able to get by when presented with mild problems, when the going gets tough ... the skilled helper must refuse to be helpful (quoted in Flanagan, 1982)

In a situation of stuckness with a couple it may be effective as a strategy to admit to not knowing what to do next. I believe my initial contact with Robert and Susan was doomed to be cast in the mould of ineffective but inevitable. I admit to having felt intensely frustrated

at not making progress; I felt that I didn't deserve to be the target for Susan's anger and invective, but I felt sorry for Robert and his call for help was quite dramatic. Both of them were in fact calling for help and their rejection of what was offered was a measure of their distress (Haley, 1980).

However, my involvement was in fact a very important part of the therapeutic intervention as it allowed for the engagement of the couple and allowed me to enter into their relationship on a similar level (Palazzoli et al., 1978). Robert's and Susan's strength as a couple lay in the bonds that had been forged over the length of their relationship and it was not acceptable for outsiders to presume to come between them in the guise of helping. It was necessary to engage Robert and Susan on their terms first before change could be accomplished (Perry, 1988). The occasion of respiratory distress established a different stage in their circumstances and fortuitously enabled us to engage them in a partnership of care for the future.

The necessity for a family conference came about because of the need to protect the staff of the unit from a difficult situation in which they too were becoming enmeshed in Robert's and Susan's relationship (Olson, 1989). A crisis creates an 'access point', during which patterns may be easily altered even as a beneficial side effect of another process (Rait and Lederberg, 1989). The new situation for Robert and Susan was the hospitalisation and their reaction to it was indeed dramatic. In devising the script for the case conference we put aside the past and concentrated on the problem at hand. We felt that we didn't have the time or the resources for a long term psychotherapeutic intervention (Haley, 1980: 44-6). We needed to engage the couple intensely and set out to create a paradox through acknowledging our helplessness in the face of the strength of the bond between Robert and Susan. We hoped this would allow the situation to be considered from a different perspective so that the accusations of blame could be defused. Our hope was to allow Robert and Susan to move on and reframe their relationship (Watzlawick et al., 1974). We had been able to accord selfless interpretations to Robert and Susan's motives, which we hoped would effect a change and give us a way out of the stuckness of the moment. (Budman and Gurman 1988). It came as a pleasant surprise to have it work so well and it had the positive effect of allowing Robert and Susan to be in the position of taking control over their decision making once more.

CONCLUSION

Mark Twain is reputed to have said, 'If the only tool you have is a hammer, a lot of things will start to look like nails'. In the situation of counselling and therapy, reframing and paradox are obviously useful tools to have access to. In this particular instance we were fortunate in having a window of opportunity arise for their use. However, in many cases the anxiety generated by the need to be helpful can cause us to leap in with the ham-

mer in the hope we have a nail to address. Often we are faced with a screw and although it is possible to drive it home with a hammer the fit is never optimal and the join falls apart.

We need to approach problems at the pace given by the situation. There may not always be the magical solution available. There *is* a need for the practitioner to engage the patient and the family in order to secure credibility with the family so that there is a possibility to exert leverage when and if an opportunity exists. Timing is critical and the wisdom gained by practitioners of family therapy and Hospice and Palliative care is based in long experience. If the stage for the intervention is not right, reframing has the potential to fail, or worse, be seen as patronising. Teamwork is essential in Palliative care and the multidisciplinary approach is more likely to be effective than the singleton practitioner.

However, the reality is that changes are happening in our hospitals and within our profession. Part of the change has been brought about by the subtle influences of Hospice and Palliative care in showing how hopelessness and helplessness can be managed effectively. The major force for change is society itself. The informed consumer will no longer put up with patronising 'Doctor knows best' attitudes. The euthanasia debate in Australia and overseas has focussed on the deficiencies of the provision of Palliative care and while the provision of superb Palliative care cannot hope to alleviate all suffering, it will become an expected option within mainstream health services.

The challenge for Hospice and Palliative care is to maintain the balance between the art and the science of care. To prosper in the mainstream, Hospice and Palliative care, like family therapy, needs to draw deeply on its strengths of teamwork and its focus on the individual and the family as the unit of care. The temptation to concentrate on the measurable and the 'scientific' and abandon the 'soft core' must be resisted. Hospice and Palliative care should reflect the humanity of society (Sommerville, 1994).

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