Finding hope and healing when cure is not possible.” These are simple words, but sometimes hard to do. Stuart et al.1 focus on dying children with brain cancer; however, caring for dying patients is nearly universal among the medical specialties. Drawing on their knowledge and experiences, the authors offer “ideas” and a “mindset,” which can be learned and developed by clinicians and in turn augment the resilience of dying patients and loved ones. These ideas (and others) and mindset, which align with guidelines,2 are herein summarized and illustrated by the philosophy and life of the legendary physician, Sir William Osler, who died 100 years ago (1849-1919).

The authors hold that dying patients need healing. This seemingly illogical claim acknowledges that a person is not just a biological organism, but also has a mind, spiritual life, and community. The authors assert that the foundation of healing in this setting is the evolution of “focused hope,” which emphasizes cure, to “intrinsic hope,” which emphasizes quality of life (eg, symptom control and family time) and meaning making (eg, relationships and spiritual matters).

Clinicians can facilitate this evolution of hope. Key first steps include alleviating pain and symptoms and providing clear information regarding prognosis, both of which Osler routinely practiced.3 Stuart et al note that providing clear information does not diminish hope, but leads to letting go of focused hope and creating meaningful treatment plans. Providing such information can be difficult; SPIKES (set up, perception, invitation, knowledge, emotion, and strategy) is a useful evidence-based approach: set up ensures sharing information in an appropriate setting; perception entails assessing the patient’s perception of the situation; invitation involves obtaining an invitation from the patient to share information; knowledge means sharing information; emotion involves addressing patients’ and loved ones’ emotions; and strategy includes a summary and next steps.4

Stuart et al note that one can learn from what the patient’s body says about the illness journey. Doing so creates special moments and promotes living in the present (rather than being focused on future goals). The authors recommend clinicians gather information about patients’ and loved ones’ concerns with the “ask-tell-ask” method. For relationship-building, the PEARLS (partnership, empathy, apology, respect, legitimization, and support) are useful: partnership articulates the nature of the patient-clinician
relationship; empathy notes insight regarding the patient’s situation; apology acknowledges missteps that occur during the illness journey (e.g., clinicians late for appointments, apparent insensitivity, etc); respect appreciates the patient’s experiences and efforts; legitimization recognizes that many patients experience frustration and numerous other challenges; and support specifies that the clinician will not abandon the patient.5

Most clinicians know colleagues who are expert at guiding patients and loved ones through the dying process. William Osler is an historical exemplar. During the 1918 influenza epidemic, Osler made house calls to many patients including Janet. Janet’s mother described Osler’s last visit:

The most exquisite moment came one cold, raw, November morning when the end was near, and he mysteriously brought out from his inside pocket a beautiful red rose…and told how he had watched this last rose of summer growing in his garden and how the rose had called out to him as he passed by, that she wished to go along with him to see his little lassie. That evening we all had a fairy tea-party, at a tiny table by the bed, Sir William talking to the rose, his “little lassie”, and her mother in a most exquisite way; and presently he slipped out of the room just as mysteriously as he entered it…and the little girl understood that neither fairies nor people could always have the colour of a red rose in their cheeks, or stay as long as they wanted in one place, but that they nevertheless would be very happy in another home and must not let the people they left behind, particularly their parents, feel badly about it; and the little girl understood and was not unhappy.6(pp620)

For Janet and her mother, Osler exquisitely facilitated the evolution from focused to intrinsic hope. Healing occurred even though Janet’s mother knew her daughter was dying. Another example includes Osler’s care of a boy who nearly died of whooping cough. He visited the boy often, clearly communicated the prognosis to the boy’s father, and yet cheerfully provided pieces of sugar sprinkled fruit, which the boy enjoyed. An observer noted, “It would…be impossible to find a fairer example of healing as an art.”7(p2237)

Stuart et al recommend that clinicians be “determined but compassionate” when caring for patients and loved ones with unyielding emotional defenses at the initial encounter. As trust builds, the door to intrinsic hope and healing may open. They describe Laura and her child’s physician who facilitated opening this door: he answered questions honestly, listened more than talked, didn’t rush, sought and respected opinions, wasn’t defensive, wanted the best, was available each step of the way, etc. In contrast, clinicians should avoid behaviors that obliterate hope (e.g., saying, “nothing more can be done”).

Osler was aware a clinician’s behaviors and mindset can affect patients. He said, “It is an unpardonable mistake to go about among patients with a long face.”8(pp405) He believed clinicians should act according to the Golden Rule towards colleagues and patients8(pp451) and cultivate “a cheerful equanimity”9(pp8) and “a judicious measure of obtuseness as will enable [them] to meet the exigencies of practice with firmness and courage, without…hardening the human heart by which we live.”10(pp5) Along these lines, Stuart et al believe dying patients and their loved ones draw strength from clinicians who possess this equanimity and in turn become more capable in confronting their own uncertainties, fears, and losses.

Nonetheless, as noted by Stuart et al, some dying patients and loved ones experience despair. Addressing despair—not avoiding it—is part of healing. Clinicians should harness resources to mitigate contributing factors including exhaustion, neglected family duties, and financial stress (e.g., social work, spiritual care, bereavement counseling, support groups, palliative care, etc) and work with
patients and loved ones to establish goals of care including plans for the last days.

Stuart et al conclude that the outcome of healing when cure is not possible is freedom—perhaps found in making a conscious choice of letting go, being unencumbered by medical illness, meaning making, and so on. Osler’s own death illustrates this freedom. During late 1919, he developed bronchopneumonia and did not doubt the outcome (eg, “…I’m sorry I shall not see the post-mortem.”6[pp671]). For cough and pain, opioids helped (“Shunt the whole pharmacopoeia, except opium…What a comfort it has been!”6[pp671]). During this time, he sent cheerful postcards to family and friends.6[pp676] A commentator noted:

His perception of the inexorable progression of his disease and its fatal outcome allowed him to actively and intelligently participate in his own generally palliative terminal care, settle his affairs, and tend to the emotional needs of friends and loved ones. He died peacefully…at home amidst his friends and family.6[pp235]

“Finding hope and healing when cure is not possible.” These simple words are sometimes hard to do, but they are doable—as illustrated by the experiences of Stuart et al and the philosophy and life of William Osler.