SPECIAL ARTICLE

CANCERPHOBIA AND THE MEDICAL PRACTITIONER

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Cancer is surrounded by a psychological atmosphere which I have on previous occasions referred to as " Cancer Smog ", and this " smog " affects nearly 100 per cent of the population, not excluding the medical and nursing professions. It does affect however the latter two classes of persons in a different way to that in the case of lay people. Before going into details it is necessary to say a little more about this " Smog ". It embraces not only cancerphobia but also two types of " Cancer Apprehension ", " Personal Apprehension " and " Impersonal Apprehension ".

" Cancerphobia " is a term frequently used but seldom justified. The best definition of such a case is a person who is so worried by the idea that he or she may have cancer or will get it that it affects their normal way of life. These people must be treated by a psychiatrist. Such a condition is comparatively rare, although it causes a few suicides each year.

It is doubtful if there are any cases of true cancerphobia among doctors or nurses, but what is common among these people is the *fear that they should be considered to suffer from cancerphobia by their colleagues.* This is the reason why some doctors and nurses do not seek advice in the early stage of the disease. I have heard a story, it may not be true, that a member of a hospital staff went for investigation to another hospital rather than risk the possibility of being considered a " cancerphobia " by his own colleagues. Of course everybody remembers the case of a doctor or a nurse who conceals an obvious cancer, but forgets a number of lay patients who have done the same, and whom they have seen in the course of *one* outpatient session.

The fact that there are a few cases of neglected cancers among the profession, has on many occasions been used as an argument against the value of cancer education. In May 1953, a paper was published in *Cancer* by Robbins, Macdonald and Pack in which it was suggested that doctors were equally neglectful in seeking early advice for themselves as lay patients. I showed this paper to a medical statistician in this country and he said that statistically it was valueless. It seemed that no differentiation was made between types that showed symptoms in the early stage, and those that did not. The comparison was made between 229

doctors and 2,000 lay patients. I can speak from personal experience about this fear of appearing to suffer from cancerphobia, because about ten years ago I had very doubtful symptoms of a gastric carcinoma, but realizing this fear I boldly consulted my colleagues, who found on x-ray examination a very distorted pylorus, and achlorhydria; they therefore decided to explore. On the day before I entered hospital I told a colleague that I could not attend a committee as I was going into hospital for investigation re gastric carcinoma. His reply was " Well you must know you have not got one or you would not go in." On the day I came out another colleague said " Of course you were the only one who thought you had it." Would either of these remarks have been made if it was any other disease?

Cancer apprehension is of two types, " personal apprehension " where the patient notices some symptom for which there is no obvious cause and at once thinks " can this be cancer? ". A very good example of this is a woman with a slight pain in the breast. She may go on worrying for months until the pain disappears, or she may go to her doctor in the hope he will say " there is no cancer " but does not mention her fear and failing to get this assurance comes again and again and lives on the doctor's doorstep. There must be thousands of such patients throughout the country, and if practitioners were more alive to the existence of these " cancer apprehensives " and said a few words to them about cancer they would markedly diminish the size of their surgeries. I used to see a great many such cases in outpatients, and it was my custom after examining the patient, to say " I am glad to say there is nothing serious and no evidence of cancer ", emphasizing the word *cancer*. Time after time the patient would say " Thank God, that is what I really came about ".

This is not the place to discuss the vexed question of " Should the doctor tell? " when the patient has cancer, but *the whole attitude of doctors about cancer is seriously affecting the relationship between doctor and patient.* On several occasions at the end of a lecture a member of the audience has stood up and said, " You ask us to consult our doctors if certain symptoms occur which might possibly suggest cancer, but I could not talk to my doctor about cancer, I hate being laughed at ". Many patients who otherwise have complete confidence in their family doctor, will not believe a word he says if they think, however mistakenly, that cancer comes into the question.

Impersonal apprehension is very common. In this case a person who does not worry about cancer believes if he or she speaks to a friend about the disease, the addressed will be frightened. Evidence can be obtained about this, if at a lecture the audience are asked

how many of them would prefer to be told supposing that they had the disease, nearly the whole audience will hold up their hands. If, however, this is followed by the question " How many of you think a friend or relation should be told? " scarcely a hand goes up. This impersonal apprehension does a great deal of harm by increasing " hush hush " concerning the disease, and thus causing unnecessary fear in thousands of people, also causing people to delay going to the doctor.

It is not difficult to see why a family doctor should loathe the disease, and often is not interested in it. He sees on an average only about 15 cases a year and these are often in an advanced stage of the disease when they first seek advice. He sends them to the hospital, but most of them return to die at home where he has to treat them. The management of such cases is the most trying work that the family doctor has to undertake. It may become a little easier as methods for combating pain improve and become more generally known.

Although the family doctor only sees a few cases of cancer, he probably sees hundreds of cases of " cancer apprehension " but unfortunately does not always recognize them. These he can cure without any operation and will perhaps do more good that way than curing a few real cancer cases, because it has well been said " It is better to die of cancer than live in fear of it ".

Gerontology and the Health Visitor. J. V. WALKER, M.D., M.R.C.P., D.P.H., *The Medical Officer* (9th January, 1959), **101**, p. 20.

The medical officer of health for Darlington (pop. 83,000) describes a cohort study of old people which lasted five years and produced " hardly anything of value to report ". He discusses the reasons for this disappointing result, and passes on to describe his methods of collaboration with the local general practitioners. He circularizes these weekly with news of notifications, and other items of interest. He gives the services part-time of his superintendent health visitor to act as a referee on priorities for hospital admission of the chronic sick, which service meets with general approval. But excellent though his liaison with the local family doctors sounds, he has been able to get only three names of old persons " likely in due course to need hospitalization ".

He makes the important point that attention to possible malnutrition or other cause of deterioration in health may prevent or delay the need for hospital beds for old people.
