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IN MAY 1969, I FOUND MYSELF A RELUCTANT GUEST OF THE Viet Cong. My first thoughts—after those castigating   myself for the stupidity of having been nabbed—were about my father, a gentle man, a World War II veteran. Though intercontinental communications were relatively primitive in those days, it was only hours before he learned that his son was missing in Viet Nam.

It wasn’t until after I had been home for some time that I appreciated the power of worry to destroy. I learned that the physical pain of my ordeal paled in comparison to the terror my Pop experienced for the few days until he was notified that I had managed to slip away from my captors. Though he began to smile again a year after I got home, I’m not sure he ever recovered.

Though I have been in practice for many years, it was not until recently that it finally crystallized in my mind just how noxious the fear and worry my father suffered can be for patients. To allay those painful and counterproductive emotions is basically why people come to see us physicians. Cervantes believed the inn is worse than the journey. lam suggesting that the anxiety can be worse than the disease.

I am closing in on 60. Over recent years, my prostate- specific antigen level had been mildly elevated, and I had dutifully taken myriad 6-week courses of antibiotics, none of which had lowered it more than trivially. On a recent physical examination, I was again found to have an elevated PSA level, but this time a frank mass was detected on palpation. The urologist chose, despite my respectful protests, to have me complete another 6-week course of antibiotics before he would consider a biopsy. He noted, “The chances of cancer are low, so we can wait for the biopsy as long as we want.” That, apparently, was all he felt necessary to allay my fears. But even if my chances of having cancer were zero, this physician had committed himself by uttering that “magic” word, cancer.

Over the past 30 years, I have come to understand, as have we all, that cancer is one of the most loaded words in the English language. One of the four-letter variety shouted from a church pulpit during Evensong on Christmas Eve would have less of an impact on lives, for it would not engender the worry and depression that the fear of cancer does. Once that word is spoken, we have started a process that wrests time from our patients’ lives. That word steals a finite number of the very few precious minutes, hours, or days we are granted on this earth. And once that word is spoken, it becomes our unavoidable charge to minimize that vanished time, just as we seek constantly to minimize physical pain.

In my own case, though I was not terribly fearful of death, my having cancer of the prostate would have made a profound difference to my wife and children. In that sense, the decision to delay my diagnosis stole time from them as well: days and weeks, and finally months, that need not have been squandered in the constant haze of worry.

Since most health care professionals deal with the world in terms of solutions, not problems, I offer the following proposal: When any of us either uses the word cancer or has a patient who can reasonably believe there might be a chance of cancer, we make a commitment to obtain the diagnostic information immediately. In doing the research for this essay, I have learned that it is generally possible, with persuasion, to obtain most standard tests and provide the patient with the results within 24 to 36 hours of presentation.

That may mean slipping out of the examination room to make a couple of phone calls to gently twist arms to get the MRI or the biopsy done posthaste. But the time taken for these calls would be no more than any of us would spend if it were our own child with a white count of 40000. And how long would we wait on the phone to arrange for a biopsy of the breast mass a sister had discovered during her shower that morning?

That also means time spent during discussions with the patient and family, giving them the opportunity to be provided with the diagnostic information over the phone. This is the matter over which I have run into the most resistance from colleagues. All I can offer is that on the mercifully few sad occasions I have had to deal with this over the years, I have simply, but boldly, told patients, “I don’t think there is a problem, but if there is, we will define it, and then treat it; and I need your promise to be tough, because we are going to deal with anything that gets thrown at us like a battalion of soldiers.” I have never been sorry for an instant that I provided my patients with dreadful news sooner rather than later.

I am not suggesting that all of our patients are sturdy enough to handle this news in a fashion that won’t make us uncomfortable, but they’re going to get the information, and I am proposing that the sooner the uncertainty of waiting is stripped away, the sooner they may deal with the challenges ahead.

Many physicians argue that it often doesn’t matter if a diagnosis is delayed, because with many cancers, the outcome is not affected by postponed treatment. Sometimes there is a delay because there simply is no treatment. Yet even if we can offer no cure, we can define the problem and design a plan in which there is hope; for there is always hope, at the very least hope for keeping a patient comfortable, hope to see the flowers of spring, or feel the cleansing winds of autumn, or touch the unsoiled snows of winter. We need to fill our patients with hope every time we see them.

This commitment also means being willing to come in a half hour early the next morning to meet with the family, to make time, something we are often accused—generally unfairly—of not doing.

And I am not suggesting by any means that we drive ourselves crazy providing instant results of basic diagnostic tests like cholesterol and HgAlc, or MRIs regarding the status of a 50-year-old skier’s anterior cruciate ligament. I am only asking that we exercise the same alacrity in obtaining a diagnosis we would expect for our own loved ones when the disease is life-threatening.

In my case, 7 weeks after the urologist told me he needed to rule out cancer, and with the mass unchanged, he performed a biopsy. I then waited another week, a total of 8, before he had me come in for the results. I have since spoken with the pathologist who examined my biopsy. He informed me that he had, in fact, read it as negative the very day of the procedure. He would have gladly telephoned the urologist with the result, but there was no note on the pathology slip requesting that service.

Perhaps what bothered me the most was that when I dutifully sat in the urologist’s office waiting to be seen, most of the patients were old men wearing baseball caps embroidered with the emblems of the units in which they had served in World War II. So their wives had to wait in fear 60 years ago, at the beginning of their lives together, and now they have to wait again at the end.

I don’t think they need to.

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Any important literary work is like the Trojan Horse at the time it is produced. Any work with a new form operates as a war machine, because its design and its goal is to pulverize the old forms and formal conventions. It is always produced in hostile territory. And the stranger it appears, nonconforming, unassimilable, the longer it will take for the Trojan Horse to be accepted.

—Monique Wittig (1935-2003)

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