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Cancer and autonomy☆

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Abstract

The idea to be reflected upon in this article concerns choice as a basic act in case of illness. Choices are precondition for decision making, decision making is crucial during the course of an illness. The making of choices depends on autonomy as a characteristic of identity. This article describes different psychological characteristics of autonomous behavior, some options for the health professional to accordingly interact with the patient, his history and future and the consequences for the provoking of stress during the diagnostic and treatment procedures. Stress remaining an important and probably decisive factor in the course of an illness like cancer. © 2002 Elsevier Science Ireland Ltd. All rights reserved.

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1. Introduction

"I am standing against the wall. I have no choice. The doctor told me I have a prostate cancer and I must have an operation and chemotherapy. It is terrible. There is no choice". How often do we hear voices like this one: people facing a crisis due to a terrible illness, telling they have 'no choice'.

It is an understandable reaction, because it is an emotional reaction. But it is also unrealistic and not rational; emotional and irrational are not necessarily the same though. For the patient's environment, including the doctor and the nurse, it is important to understand what the patient is saying, it is important to understand the emotional reaction. But it is also wise to reflect with the patient on his saying, clarifying the unrealistic aspects of his statement.

2. Primary reflection

There are many elements in the statement made we might consider for reflection. Most important to clarify to the patient are the unrealistic aspects of the statement that he has "no choice". Of course, the patient has several choices and he has to become aware of these options because of many reasons I will explain later on.

What are available choices in a case like this one? The patient may choose to do what the doctor says. Why does he make that choice? Probably because he supposes to survive when he follows his doctor while he is too upset and too scared to think about something else. But there is an implicit choice in the background he hardly seems to be aware of. Why is it not the patient's first choice to state that he wants to live, that he wants to survive? No matter what the road back to life may be. The difference is that if he follows his doctor he makes a choice for a passive regimen in which he is the follower and the doctor dominates the course of the illness, and consequently his life and or death [1]. If he makes a choice for survival he makes at least a basic choice, which brings the important consequence that he remains in charge of his life and illness; he opens options and one of these is that the doctor can follow him or guide him with medical considerations. But in that case he made that choice himself and not somebody else. Just as basic is the consideration not to choose for life and to choose for a terminal perspective: no curing treatments and ultimate death when the cancer spreads and affects other vulnerable parts of the body. It certainly happens that patients make a choice for death. They may have a diversity of reasons; the important thing is that they make their own choice. It even may be a positive choice within the context of their life, depending on their intrinsic motivations.

A choice for life can encompass several options: some patients start praying or meditating, go for a Simonton

☆ This paper is dedicated to Professor David Thomasma, my best friend and professor in medical ethics at the Loyola University, Medical Humanities, in Chicago, who died April 25th, 2002.

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therapy, consult an alternative healer or, as a free chosen option and delegation of responsibility, ask the doctor to start the standard treatments of surgery combined with chemotherapy and/or radiotherapy. Even here we find several options. No matter whether the patient chooses for dying or survival he is the one who makes the choices and he is the one who controls his own situation. He remains in charge. An important aspect of course is that prostate cancer is not necessarily a killing cancer and implies good opportunities to survive. But this is the case with most of the cancers: all of them imply a certain risk of dying and a chance of survival. There is an enormous variety in these figures and there is even much more variety than the average patient is aware of. It is important to include these figures as well in case of reflection with the patient on his statement that he has no choice. I will return to this aspect later on.

3. Reality, choices and some theory

What we have been observing in this very brief introduction is that the statement 'I have no choice' is an unrealistic statement. When becoming more realistic there are many choices; not all the options are rational options, some of them may be emotional or spiritual but they are the patient's choices anyhow. Several patients though, being confronted with the medical message about their cancer will not make a statement and spontaneously figure out what their options are. Many of them even have made up their mind before, considering that at some moment in their life a thing like this might happen. Perhaps they did not anticipate the concrete message 'cancer' as such, but the idea of any event occurring in their life, obstructing the road onto the goals they projected for themselves, may be developed long ago. They also have faced clear thoughts about the answers they were to give in those circumstances, probably learned from other comparable events.

Other patients will remain in the claustrophobic jail of 'having no choice'. Denying any choice they really think they have no options other than following the authority of the doctor who tells them they should have their operation and their therapy. Perhaps they do not even consider the statistic chances to be cured. They remain the 'fear and tear' category, which offers its life and its course to external powers.

3.1. Locus of control

Within the theories on locus of control the first category of patients mentioned encompasses those who may be called "internal" controlled, while the second category can be described as "external" controlled identities. The theory on autonomy has more nuances and is more effective if applied in healthcare practice since it is related to problem solving theory [2]. I will just make some brief remarks.

External controlled individuals tend to live in a chronic dependency on the outer world searching for indications from external forces like God or dominant persons how to get organized in their life. We can observe this behavior in couples where one of the two is the dominant person and the other one is the follower; they really may come in trouble in case the dominant person gets ill or dies. These people feel good and can function quite well in hierarchical organized situations like a church, strict organized group or companies. The internal controlled person, contrarily, is a person who does not like to be directed by outer forces, he wants to live his own life, organize his own things and generally dislikes hierarchical relationships. He is the one who likes to organize his marriage and the household, he is the free enterpriser. The fact that he prefers to do his own things does not necessarily lead to a 'dominant' person. Generally, he even has a good understanding of other people's freedom and is able to have respect for other people's own choices. The dominant, authoritarian person often compensates his own uncertainty and is not easily ready to respect other people's internal controlled way of living. Quite often they are not real autonomous people, in the contrary they use authoritarian behavior as a compensation for lacking power or consciousness.

These notions on two different styles of coping with life are just an introduction to the concept of autonomy but it is important to understand already now that if we bring a real external controlled person in a situation where he has to make his own choices and make his own decisions he might develop a significant stress. The same counts for the internal controlled patient who, for example, meets a very authoritarian doctor. Here the man who is used to make his own decisions meets a situation that does not fit his personal attitude which also may create real stressy complications. Before going to the issue of autonomy it has to be mentioned for the reader that there are, of course, many slow transitions from the internal to external controlled attitude: like all theories on behavior, it is never just black or white, most of the nuances are somewhere between. Nevertheless, when considering somebody's lifestyle and personal history the dominant attitude may become more or less clear. Which is in certain circumstances, like the occurrence of illness, at least an important thing to be aware of.

3.2. Autonomy

The psychological concept of autonomy focuses more on problem solving, although attitude is an important factor here as well [3,4]. The idea of personal control has important consequences when it comes to coping with daily life problems, autonomy gives more insight in the structure of the processes of problem solving. To better understand the concept I distinguish two important lines: the first line is related to *future*, the second to *anticipation*. They are a crucial basis for the act of problem solving.

For several people the idea Future implies a certain image of the life to come. This may vary from the young girl who dreams about becoming a lawyer someday to grandma who is looking forward to her children's visit next week. What

they have in common is that they are able and willing to project their ideas into a short or long-term future and manage their life in such a way that they may concretize that image. Other people are less aware of the idea future; they do not have real images of a time to come and in fact they are lacking what was called by some lifespan-psychologists as a 'blueprint for life' [5]. This does not imply that they do not think about future, but the thinking has less structure, it is a vague enterprise without the personal significance of a controllable direction to be aimed at.

Anticipation is the awareness of the possibility that something sometime may happen implying an obstruction on the road we are going or that enables us to adapt to certain circumstances to ease the intentions we have in mind. Anticipation is a kind of risk-calculating facility people have and which can be used in a more or less active way. Learning and life experience are important factors in keeping the anticipation alert. This implies more or less that during their life some people do not anticipate at all and other people are actively and consciously anticipating on some kind of event to come or to be organized.

To understand a person's problem solving strategies it is helpful to cross the line of future with the line of anticipation. We have categorized the options in this way: F+/A+, F+/A−, F−/A+ and F−/A−. In this way we categorize persons who have a clear image of a future and who are ready to anticipate the possible obstructions, persons who have a clear image of a future but who are unable to anticipate any hindrance, persons who have no futural image but who are always aware of what can go wrong and at last people who are lacking any image of a time to come but also do not anticipate any real problem on their way. These four categories are very important when it comes to coping with illness and especially with cancer.

Herewith we can return to the theme "I have no choice", I used in my introduction: no choice?

4. Choices and problem solving

In case of an illness such as cancer we have to face two kinds of problems. The first one is the illness itself, which is a problem in itself, and the second one is how to get along with that problem. The first one is an undeniable fact that has no solution in itself. For the patient there is the problem how to solve the problems occurring in his life as a consequence of this fact. The patient we introduced tended to state that he had "no choice". Let us have a look at what the theory on autonomy can tell us about that situation.

4.1. F+/A+

The F+/A+ patient is seldom a patient who is completely surprised by the (cancer)-message but he starts to think about the consequences. He considers what the implications are now and for the near future and he certainly tries to get more information about the affliction. He is willing to ask his doctor more details related to the diagnoses, but he also tends to look for books or journals to inform himself about the chances, the risks of some treatments and the therapeutical options. His first decision is to gather more information knowing that solving a problem in a satisfactory way needs sufficient information. Probably this is what he always does if confronted with any obstruction in his life. We have to understand that the leading line is the future and the images of a future to be realized. The patient does not want to be interrupted more than necessarily and at least wants to know how to redirect his life plans. The reason he can remain in control of his situation and become active in the collection of information is in the anticipation. He probably was surprised by the message about his cancer, but not by an event occurring in his life. As a young man he was aware that he might have an accident one day, that he might meet a nice girl to marry, that he might not pass his examinations 1 day: while getting older the pallet of options becomes wider and wider. Being over fifty one can know that the risk of a life threatening illness increases, one is aware of the fact that cancer is one of those possible illnesses.

In fact the autonomous person is aware of what can happen in his life. Of course he is surprised when he receives the message, but the message was a calculated risk, projected against the blueprint of his life. So some younger people will try to use all the energy they have to fight the illness, the man over 80 may come to the conclusion that the message is a welcome message, because he sees how he lives at the end of promises and is ready to leave.

Within the process of decision making conditions are important factors and these factors change with the progress of life. The content of these conditions changes, the patient's inclusive calculation remains the same kind of activity all through his life.

If this patient meets a doctor who tells him immediately what to do, what the risks are and what kind of treatment he prescribes the storms may come along. This is the patient who wants to make his own calculations, who wants the doctor as a source of information and as the technical instrument to apply the decision they came to within an open and straight dialogue. If the doctor is an autonomous person himself who understands how the patient's mental mechanisms work he can accept and they can create a productive cooperation together. Even if the patient decides he wants to walk another road than the doctor had in mind. May be in these cases it is even easier for a doctor to go a less orthodox medical direction. Siegel is an example of a man who understands how to get along with these options [6].

4.2. F+/A−

When focusing on the patient we described as belonging to the F+/A− category we will watch another picture. This is the person who certainly has a picture of a future but never calculated the risk of any life event obstructing the mental

blueprint of future. This is the patient who may really get in trouble and emotionally panic since he does not know how to handle this situation, he has no (effective) experience in getting along with problems and certainly not with life threatening situations. This may be because he is still young and had no opportunities to learn to cope, for example, the young boy of 16 who discovers to have testis cancer, or he is older but never became a full grown adult learning from life experiences. It may be that he is not able to learn as an identity, may be he went trough such a neurotic development that the idea of obstructions simply was unimaginable or could not be integrated in his personality. This can happen, for example, with extreme narcissistic personalities whose life is so ego-centered that the calculation of any risk does not fit their identity image. In case of emergency the doctor may expect real trouble and be aware that this patient needs a good guidance and clear instructions. The best one can hope is that this patient can use the crisis as an active learning experience for the future. Of course the guidance has to understand the background of this identity, being aware of the fact that for many people these crisis situations are a precondition for learning to cope with life. A positive challenging approach within a strict framework appeals best the patients potentials, because it combines the challenge with feelings of safety, the patient needs in this, for him, primarily hopeless situation. If this patient says he has ‘‘no choice’’ he is right in the sense that he does not know how to make choices though, but in several cases he can develop the personal facilities to make choices for himself later on.

4.3. F−/A+

A real problem is the category F−/A+. They are the persons who live in a constant expectation of the next trouble. They have no real image of any future but the only focus in their life is what may go wrong. ‘‘I dare not think what to do when my husband will have an accident’’. The message of cancer may create something like ‘‘look, that is exactly what I was waiting for’’. The problem is that these people are in a chronic stress, waiting for any trouble but never tried to consider what they might do in such a case. They do not learn to solve possible problems although they have all the opportunities to do so. The lack of a futural image probably implies the lack of a facility to control one’s life-situations and one’s life in general. It seems that ‘‘I dare not think’’ is nearly literally the truth, though they think all the time, but not about how to effectively solve any problem. This is a group of people being really depending on a someone who takes the lead, offers safety as far as possible, and leads them through the labyrinth of diagnostic and treatment procedures. Of course it is worthwhile to try to improve their independency, since there are several identities for whom this dependency is a learned behavior, at home as a child or during marriage (‘‘let me do this for you dear’’), so they are sometimes able to re-learn a more autonomous behavior. But it is not exceptional that those people, belonging to the group of more extremely external controlled people, invite a certain gratifying behavior in healthcare people who have the feeling they now really can do something for someone who is really grateful. This depending attitude is an easy one because these patients are always scared to do something wrong so they will never oppose the doctor’s or nurse’s regimen. They will feel safe in a strict pattern of supportive help, even authoritarian atmosphere, and will be a grateful patient. But be sure that as soon as something seems to go wrong this is the first patient to panic again since that is the behavior they are conditioned on.

4.4. F−/A−

The easiest patient in the hospital is he who represents the F−/A− category. They have neither image of a future nor a picture of what may go wrong. So they are easy to manage, seldom get into panic: what tomorrow brings, tomorrow will bring. For some of these people counts that they have a sometimes, impressive trust in God, and otherwise their external controlled attitude makes them easily depending on an authoritarian doctor.

They are the patients we might easily overlook in the ward since they are the people who live in a chronic state of resignation, waiting a long time to complain or to ask attention in case something goes wrong. They do not want to be a nuisance. In case of pain, for example, they will wait longer to ask attention, because they do not want to ask extra attention; there is a kind of certainty that things go as they should go. In some ways they create a certain amount of risk for themselves although they will never admit such a thing. It may be clear that this attitude may vary from a real positive dedicated dependency on external (religious) forces through blind political dependency without any criticism through a life lived like a leaf in the storm.

In general, it is difficult to change this attitude, learning to take responsibility for ones own problems is not an easy challenge.

4.5. Conclusion

Summarizing we have seen four main categories of varying autonomous behavior, implicitly four main categories of problem solving. Once again I want to stress how these categories are seldom found as extreme and clear as described over here. The normal situation for most people is somewhere between the extremes with a more or less recognizable accent in a certain direction. Nevertheless, we have to be aware that even if the problem solving strategy is not as extremely clear as described before, the personal accent determines the way a patient copes with the problem to be faced. In several studies we mentioned how this problem solving strategy is not just a specific behavior but can be perceived as a characteristic of an identity [7]. A whole identity is characterized by the way it confronts problems. To be clear, this does not only count

for patients but of course for all people including also healthcare workers.

An important consequence is the question in which way the autonomy categories interact. To come to an answer an important additional remark has to be made. An identity is characterized by its problem solving strategies and consequently by the degree of autonomy. But autonomy is not always just a static characteristic: there is much in a person's life which determines whether he or she had sufficient opportunities to develop autonomous behavior. A traumatized young woman is not apt to project her blueprint of life any more, she is brought in an atmosphere of mere survival, how autonomous she may have been in the past. Life experiences may improve and strengthen autonomous behavior, in the same way circumstances may have extinguished healthy impulses. Especially in cancer, where the personal participation during the illness is so crucial, it is wise for the doctor in charge not to remain at face value when meeting a new patient but to discover in which way he can activate a patient's autonomous facilities. It is always better to try for the best than just accept the at first sight easiest scenario: listen I will tell you what you have to do ... or in other words: I will tell you what I am going to choose for you. It is known from literature and clinical experience how we may be able to activate a person's autonomy in cases of crisis. Already Erikson taught us years ago how we need crisis to better grow and develop [8]. In case of severe illness I see it as a part of the medical treatment and support that doctors and nurses guide their patients in such a way that not only the body but the identity as a whole gets opportunities to grow and heal. Cassell's statement that the most important contribution of medicine is in the healing of autonomy has lost nothing of its power yet [9].

5. Interaction

We have to briefly focus on the interaction of patient and healthcare worker. The autonomous doctor is the best actor to get along with an autonomous patient, because from his own personality perspective he can accept and stimulate a patient's autonomous behavior: he is aware of the kind of freedom the patient wants and his able to offer that space. For a doctor who is less autonomous and who compensated his own F−/A− by authoritarian behavior it may become a real struggle when meeting the autonomous patient who wants to make his own decisions. He may experience this relationship as a threatening relationship. For a doctor who is not really engaged in a futural perspective for him self it becomes difficult to get along with a patient who is actively working on a future for him or herself. The important point is that it seldom becomes a problem within a relation if the strong points of the identities are facing each other; the problems rise when the weak points of the identity of the one who supposes to be in charge, doctor or nurse, interfere with the strong or even more weak points of the more dependent one. Consequently, for health care workers training and insight in ones own functioning are essential aspects in how relationships are to be developed [10].

Within the context of healthcare autonomy is an important given when it comes to making estimations how to develop the interaction between professional and patient. In addition to the personal characteristics of autonomy there are several ways to interact within the context of problem-solving issues: some more apt to stimulate autonomous behavior, some less effective [11]. The doctor patient engagement may take place on four different levels, or along four different "roads" which add flesh to the way they cope with their interaction: information, relationship, emotion and meaning. Sometimes a road is being preferred due to a need of safety or even protection, sometimes a road is being chosen due to a lack of understanding one's own limitations. Sometimes the interaction may support the healing procedures, sometimes they may introduce irresponsible stress. I want to briefly describe some of the interactive roads without extensive discussion although they are an essential additional concretizing of the autonomy dynamics.

5.1. Information

Some physicians are able to discuss problems concerning illness, diagnostics and treatment perspectives just by the exchange of information. They explain the diagnosis, the statistical risks and chances in case of a certain affliction and in the best case offer the patient the options he can use to choose. They can discuss the pros and cons in statistical terms of risk or experience known from literature and come to a decision about the road to follow. This can be done in a rational way without any personal involvement. Some physicians like this approach and some patients also prefer this way of 'working'. The level of interaction is just restricted to the exchange of information and both parties may be happy with it.

If the interaction takes place in this way it gives a good opportunity for the F+/A+ patient to get informed optimally, for example, about the statistical figures related to his illness. "This cancer may imply an average survival of 2 years after diagnoses". Without explanation about the fact that some people die within a few months and others may survive for many years, people often belonging to different categories such as age, sex or general condition, this message has a variety of consequences. For the F+/A+ patient this may become a challenge for personal search, for the F−/A+ this message may lead to diasterous panic without any follow up. The F−/A− may resign and enter the corridor of his illness with just one image which gives him the certainty that his survival will be 2 years exactly. Gould gave an impressive example of this road of information exchange after his affliction with cancer in which he was engaged himself [12]. The implication of this broad variety of impacts is that the doctor should not restrict himself to a medical diagnosis but also try to develop a preliminary image of his patient, just to understand what the patient

needs and what the patient can endure: there are other roads to go. Try to discover what kind of problems a patient engaged in his life before and what kind of solutions he found: it is often a clear indication at which level at least the interaction can start.

5.2. Relationship

The second road of interaction is not retricted to the exchange of information but is also prepared to build some kind of relationship between professional and patient. This means that the patient is not just an object but also may get some meaning as a subject. The professional should be interested in the question whether his patient is a more or less autonomous person, which means that he tries to get some insight in the style of problem solving and consequently may interact with the patient accordingly. So in some cases he will leave certain decisions more easily to a patient in other cases he will take some responsibility for choices to be made. A very decisive doctor who nevertheless has a real interest in his patients as a person once said to me "you know a patient may be very autonomous but when I see that he makes the wrong choice I certainly will tell hem who's the most autonomous of the two of us". Respect for the profession and respect for the patient come together here: the relationship becomes one of the red lines within the whole treatment procedure and is being used in favor of the ultimate outcome. A doctor or a nurse can explain to the patient how he might improve his attitude to support his own healing process. This is impossible without a minimum of personal engagement, easily developing in case of chronic disease like cancer where doctor and patient are often engaged with each other over a long time.

5.3. Emotion

There is a third additional road which might be explored in the professional patient relationship. Here is room for sorrow, for happiness, for anger, for tears in case of pain, loss or bad messages. In general, medical professionals do not favor real emotional engagement within a professional relationship, but some are not afraid to be confronted with their own emotions and are ready to share with the patient. Of course in some specific cases like in psychiatry or during psychotherapy, emotionality is crucial as an integral part of the treatment procedure, but in oncology, for example, it is more exceptional within the medical relationship. The role of the nurse is often more apt to get involved in the patient's or the relative's emotions since they have a more intensive and longer lasting contact with the patient and the relatives. Some nurses are very adequate in coping with these emotions, for others it may become an ultimate source of stress and even cause the so-called burned out symptomatology. The main thing is that it may be very important for the patient's well being to get involved in his emotions as a professional, but if the professional did not learn how to cope with these emotions and did not have any adequate training to cope with the phenomena as such he or she is not able to engage in a for the patient profitable and effective way, which is the worst thing to happen. Emotions are very important on the patient's road to healing. But emotions have a significance which is completely different from an F+/A+, F−/A+ or F−/A− identity. Professional efforts to structuring these emotions can have a positive therapeutical or healing effect, for example, because it may prevent the development of psycho trauma. The misunderstanding is that just the expression of emotions is important. Especially the learning process how to cope with emotions is essential and may become an important instrument for patients and relatives. The learning process in the coping with anger or loss or stress of any kind is important in the coping with crises as we mentioned before. Coping effectively with emotions is an important step in the increase of autonomous behavior. Strict condition is a professional who is aware of his or her structuring but controlled contribution in the patient's learning process. The F−/+ A or F−/A− doctor has to be very careful. Without adequate training in these issues there is just one message: do not.

5.4. Meaning

Many patients suffering a life threatening illness are troubled with questions about reason and meaning. Why is it me who got this illness, why does this happen in my life at this moment; patients worry about their own role, patients often feel guilty especially in cases of cancer and they want an answer. In our research we found how cancer patients often have a personal story to be used as an explanation for their illness, being unable to hide behind the screen of just information exchange [4]. Since these stories often have a negative label for the patient himself or his circumstances (work environment) they may have a negative impact on the basic attitude. In the mean time negation of these stories implies negation of the patient's identity, because the story is an essential part of his life, often even his identity. These denials work as negative as a denial of the patient's illness itself and certainly work in a negative way when it comes to healing for some patients. For some it may be exactly the reverse.

The questions about meaning of illness, and consequently life and death are important questions for the patient because they stem in a straight line from their belief systems, the spiritual aspects in their life and related problems [13].

The spiritual aspects of ones life sometimes become active and visible in time of illness and it is often important for those patients to have an opportunity to share the feelings, insights and convictions about the meaning of their life.

5.5. Summary

Autonomy is a characteristic of an identity. As we have seen so far autonomy, or the specific variety of autonomy, is not always clear to observe immediately. This counts for the

patient as well as for the health professional. The difference is that the professional ought to have at least some insight in ones own functioning and the way he or she integrates these characteristics in the professional behavior. This belongs to his professional responsibility. We cannot expect this insight from our patients, they never had a training to be a patient. The consequence is that the professional behaves from his or her own perspective and perceives the patient from that perspective. To create a good or at least effective cooperation, which we need during the often long-lasting period of illness, it is helpful to have any insight in what and who the patient is and what his problem-solving strategies seem to be. It does not take much time to invent how the patient did cope with earlier problems in his life. It is helpful to tune in to that direction, although it is quite possible to discover how a patient's strategy changes during a longer period of life challenging exposures, only remember the traumatized patient. There should be room and time to shift our perspective and focus on how the patient (perhaps) changes the application of his autonomous potentials. In this last paragraph I tried to make clear how mis-communication, or mistuning may lead to completely wrong professional strategies with strong impacts on the development of stress for both persons engaged. This is the topic we have to briefly focus on as a conclusion of this article.

5.6. The problem of stress

Stress is an extremely popular subject at the moment. In one way it might be a reason not to give too much attention to the topic, otherwise it makes sense to make some additional remarks within the context of this article. In the foregoing text the reader may have observed the variation in problems that may occur in case a potential patient is being confronted with the message that he has got a serious illness. It depends on the illness and its character, it depends on who the patient is, more or less autonomous, more or less external controlled, it depends on how the patient's personal environment reacts, it depends on who the professionals are and how they interact with the patient. As we have seen even a very autonomous patient may meet obstacles that create a lot of stress (for example, when he meets the "wrong" doctor) while patients lacking internal control may adapt (too) easily to the hierarchical situation within the hospital setting. Consequently these patients meet different kinds and amounts of stress. In the popular literature we find indications that stress is the wrong thing for the immune system and it is said that it indirectly undermines a person's physical defense. This idea is too rough and misses subtlety and variability, although it is understandable, because in the beginning of the eighties researchers became aware of the controllable and concrete relation between stress and the immune system but the use of the concept stress lacked a lot of nuances. The research carried out during the last twenty years, more and more intensely and deep going increasingly shows the nuances in the popular statement. In the first place we know from psychology already for several years that a minimum of stress is adequate and even conditional in case of beginning actions. The stimulating of the hormone adrenaline is a condition for acting, so the patient who wants to 'fight' needs at least a certain level of adrenaline to come to action. In the stress theory alertness is an important phase before action and without a minimal level of stress there is no alertness. Especially when a person comes to offensive or defensive actions he needs the stimulation of a certain amount of stress. Another aspect is that life without stress is nearly imaginable, whether one is healthy or ill, and in fact belongs to the normal status of a living organism, including the human being, because it should be perceived as the root of all adaptation. People develop a reasonable equilibrium between stress, action and life's circumstances; everyone finds his or her own state, more or less belonging to the personal package of life.

One person can deal with more stress than another one; one person has a more active immune system than another one. One identity is more able to defensive personal actions than another one and this counts also for the effectiveness of the immune system.

The real problems arise when there is too much stress for this particular person, living with a personal equilibrium he or she is used to. That 'too much' may involve a short moment, a near accident on the road, an emotional confrontation, or a long-lasting period, for example, the care for a dear partner with an increasing dependency over the years, or the child suffering a long-lasting problematic relationship between his parents.

What we know now from extensive research is that most persons, unless they have a very vulnerable condition, will meet no problems in case of a short term "overdoses" of stress, but that serious disturbances may arise in case of long-lasting overstress [14].

In addition we have to state that effectiveness of the immune system increases in case of less extreme stress. The longer an overdose of stress remains active the less effective the immune system will become. To understand this it has to be understood that the immune system always works in two phases. The first phase of action is a general response to foreign intruders, may be bacteria, viruses or cells. It is as if the immune system needs some time to discover who and what the intruder is. During lifetime the system has developed defensive cellular activity against the most familiar intruders, a 'familiarity' strongly depending on a person's environment. After some days the immune system has "found out" who the attacking force is. The more familiar the intruder, the better it is known, the more direct and effective the defensive action will be. This second phase can be understood as more specific because the defensive cells of the immune system have learned which cells are the most effective in the attack of the specific intruder. If there is a flue, caused by a specific virus, the defensive system 'knows' which specific defensive cells have to become active to attack these specific flue viruses.

But in case of a long-lasting overdoses of stress, the basic, or general, defensive action of the system is less active, it takes more days to get to the second phase of action, it takes more time to recognize the real enemy and so literally more days to come to a specific attack of the intruder. The implication is that if a foreign bacteria or cell came into the organism, the body, it takes even more time for defensive measures. Especially if the offensive agents are not known or not strictly recognized these agents have more time to do their ruinous work. Consequently the risk of a serious affliction like cancer, which implies an invasion of the system with unknown cells, or an unknown "foreign" infectious disease, increases.

Active control of personal stress is possible by means of personal activities like relaxation, biofeedback strategies, visualization or meditation. Some of those actions are more effective than others which depends on who the method introduced and trained them with the patient, but also on the patient himself. One patient is easier in accepting and applying a certain specific method than another. My impression is that the "method" is less important than the one who teaches and applies it. There are many studies showing for example that certain religious activities have the same kind of effect, although it is not be used as a method. It is important to discover which method is effective for whom. Professional health care workers, especially psychologists, should be helpful and assist in the attempts to find the best method for whom. This also implies that complete optimal relaxation to reduce stress is not possible and proclaiming such a thing is fooling the patient. The best thing is to understand that for each person there is a certain level of optimal personal relaxation which may be effective in the (re)activating of the immune system. What we can do along that road is reducing the risks of afflictions, some more risky than others; reduction of those risks to zero is fiction. We always need some stress, be it positive stress, to fight for survival. Only if we think we really have no choice, we would not even have the positive stress to optimize our own contribution for a healthy condition. And here we return to the first lines of this article, which is meant to stress how people really have choices. Precondition is the professional who is aware of his own attitude and autonomous strategies, accepting his own variety of professional choices in order to optimize his relationship with the patient.

6. Conclusion: quality of life

My intention was to describe the situation that brings some people to the exclamation that they have no choice: the discovery of a life threatening illness.

I have tried to state that there is always at least one choice left, the choice for life or the choice for death. These basic choices have far reaching consequences. These consequences are never the same for every one, differences in autonomy, differences in support within the family and differences in the medical care and support create a variety of options. Nuances in approach of our patients, understanding how this specific patient experiences his or her situation as a person may show us as a professional person the way how to cope with the patient and consequently with our own behavior. The discovery for the patient that there are choices maybe a surprise, it also may create some stress and increase the initial crisis. If we are able though to teach the patient how to get along with his situation we are able to improve the patient's life quality, which implies that if there is stress this stress may become a positive stress he or she can use in the struggle for improve the living conditions, and so consequently the conditions for the process and course of the illness.

We have an important impact on the patient's healing process anyhow, not only for now but especially for later. So why not make a choice for the best. The main condition is that we as professionals dare to develop the insight that person and illness are aspects of a same identity. This confrontation is still a problematic and emotional one, because it makes it impossible to deny our selves in the interaction with the patient. The discovery how satisfactory we can improve our own quality of life by the acceptance of that inviting challenge is probably my main message.

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