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THE PHYSICIAN AS A HEALER: RELIEF OF SUFFERING

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Suffering in illness is a gnawing sense of unpleasantness. In Hippocrates' time, being unwell was thought to stem from a misalignment of the humors. While pathophysiological mechanisms of disease have since been clarified, there remains a sensation of disequilibrium in illness. Life is different. Malaise filters everything through a grey lens, disrupting comfort and dulling joy. Everyone, if only transiently, dons the role of the patient and bears its accompanying heaviness. To be ill is to be unwell, and one can be unwell in so many ways.

Perhaps the most quintessential way to suffer is physically. Pain is a common manifestation of illness and sometimes constitutes an illness in itself (e.g., fibromyalgia). Pain serves to protect. It restricts, preventing the body from potential further harm. Even when anesthesia pushes people into unconsciousness, their body still feels and responds to the pain of surgical incisions. Pain is an experience that is difficult to put into words. At best, it is off-putting. At worst, it is debilitating.

On my psychiatry rotation, I was asked to evaluate a 22-year-old man for blunted affect and acute stress disorder symptoms. The day prior he had been hit by a car and dragged underneath for several hundred meters, sustaining multiple non-operative fractures and significant road rash. As I entered Mr. N's room, I prepared myself to speak to someone with heightened arousal. I had expected to meet someone in anxious distress; someone who was irritable and plagued by intrusive, unwanted thoughts of their trauma. Instead, I was struck by his stillness. In blunted affect, it's as if people wear a mask that freezes their face in place. He laid rigidly in his bed, completely motionless. In few words, the cause was obvious. Any movement,

however small, led to a disproportionate amount of pain. I prioritized a few questions and felt a deep discomfort in myself as Mr. N agonized to give me one-word responses. When each breath is costly, sentences are an unaffordable luxury. I quickly ended the interview. While Mr. N did have a blunted affect, it was more from enduring his physical pain than from any psychiatric condition.

In addition to physical suffering, in psychiatry I also saw how people can suffer emotionally. On the inpatient ward, I was following Ms. S – a 68-year-old woman in a severe major depressive episode. Her bipolar disorder had been stable on lithium for decades during which she enjoyed a lavish and active lifestyle. However, when her lithium was stopped due to failing kidney function (a double-edged side effect of long-term lithium treatment), she fell into a deep depression. When I met her, she had already attempted several trials and combinations of antidepressants with no improvement. A good day for Ms. S was getting out of bed, applying a bright red lipstick, and returning to lie awake in bed for the rest of the day. On bad days, she didn't leave her bed at all. In speaking with Ms. S, I learned depression is defined by absence. Ms. S told me she had no joy, no good sleep, no energy, no appetite, and no motivation. At times, she felt she had no reason to live at all (though no active plan to harm herself). The worst forms of depression remove hope altogether and I felt an overwhelming sense of despondency from Ms. S. In a life without hope, each moment seems to feel like an unbearable eternity.

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While pain can be protective, I found avoidance of others' pain was also a protective mechanism for me.

When I went to see Mr. N the next day, I found myself stalled outside his door for several moments. I stared blankly at some notes outlining what I wanted to discuss. Suddenly, I heard an irritable voice beckoning me into the room: "Come, come!". In his tone, I heard something else: "Come on now, you don't have to be afraid of me". And I was afraid. I realized I was not trying to organize my thoughts but rather trying to build the courage to see Mr. N in agony. I was embarrassed and ashamed at the reversal of roles. I needed someone in suffering, someone under my care, to comfort and encourage me just to see them.

With Ms. S, I noticed I preferred to see her last after all the other people I followed. Part of me dreaded our interactions. The longer the conversation went on, the more uncomfortable I felt. I often left Ms. S's room feeling down and hopeless myself. Whether transference or empathy, I dreaded the sensations I felt after speaking with Ms. S. The feelings she endured every waking minute, I could barely manage for a moment.

It wasn't just the intensity of distress that triggered a sense of discomfort and avoidance in me. On my obstetrics rotation, despite witnessing the excruciating pain of childbirth, I never felt a desire to shield myself from assisting in deliveries. There was some comfort to knowing labour is transient; the pain is finite and, in most cases, very meaningful. With Mr. N and Ms. S, despite their intense physical and emotional suffering, what seemed to distress them the most was an existential suffering.

"Are you worried about anything?", I asked Mr. N.

> "No, I can manage the pain and the nightmares. What can you do for me?? You know this is the second car that's hit me. Why did this happen to me? That's the only thing I need answered."

"Is there anything bothering you today?" I asked Ms. S.

> "It's all my fault this is happening to me. It's all my fault… It's all my fault…"

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Though medical therapies may reestablish physical and emotional homeostasis, there is no medication that alleviates existential distress. In the professional role, I feel an implicit expectation that physicians ought to have answers. They are people who know what to say and what to do. As Mr. N and Ms. S questioned why they had to endure their suffering, I found their distress deeply unsettling. When I grasped for words to offer, I found nothing at all. In these moments, I felt a strong urge to escape from our interactions stemming from a feeling of inadequacy and perhaps a brief confrontation with my own mortality.

A fundamental component of the healer role is accompanying people as they make meaning of their experiences. People often feel illness is a moral judgement; they would not suffer in illness if they had lived as they ought to have. Yet no one chooses to be ill. My experiences with Mr. N and Ms. S have shown me that healing must acknowledge existential forms of suffering. Physicians have a responsibility to reassure people they are not to blame and avoidance only compounds suffering by pushing people further into isolation. There is power and partnership in presence. Though there is no universal truth to be disseminated to relieve existential distress, healers create a space to address big questions in relationality. They empower people to find their own answers. Meaning, self-growth, and identity formation are all dynamically co-constructed when people interact with vulnerability. ■

References

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Biographical Note

Alex Cai is a fourth-year medical student at McGill University. Prior to medical school, he completed a BSc. in honours anatomy and cell biology at McGill University and was a national team fencing athlete. He is interested in humanism and healing in Medicine.