Compassion and cultural transformation in chronic pain

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Work by Hayes et al (1) has shown that 23% of general practitioners and 12% of specialists characterize fibromyalgia patients as 'malingerers'. They report a lack of knowledge and skill in the typical approach to chronic pain. "We are not trained to treat distress and suffering," reported a specialist. This lack is perceived by patients and reflected in the following patient quote: "Why are we being penalized for having this disability?"

As stated by Ferrell (2), "The experience of pain is an overwhelming whole-person experience with devastating effects" and caring for a person in pain requires compassion. Farley (3) also considers that "meeting a person in pain and staying with her becomes a spiritual experience". These quotes are a challenge to those who believe that increased pharmaceutical and technological approaches will bring a global solution to the management of disease.

According to a recent article in the *New England Journal of Medicine*, "The scope of the problems of management in chronic pain is daunting, and the limitations in knowledge and education of health care professionals are glaring" (4). The purpose of the present article is, as recommended in the *New England Journal of Medicine*, "to actively engage in the necessary cultural transformation to reduce pain and suffering" (4). It is, therefore, imperative that we examine cultural, technological and political influences on the provision of compassionate care in medicine.

Walt Whitman, American poet and hospital nurse during the Civil War, wrote in *Leaves of Grass*, "I do not ask how the wounded one feels. I, myself, become the wounded one." A similar reflection had been made by Maimonides in the 12th century: "May I never see in the patient anything but a fellow creature in pain. May I never consider him merely a vessel of disease". Compassion, as manifested in these quotes, comes from the Latin 'cum' and 'patio' – it literally means 'to suffer with'.

According to Covey et al (5), empathy is the foundation of synergy and of the finding of solutions in the "win-win approach" he strongly supports. Most health care professionals are empathetic and are drawn to their profession to 'make a difference'. However, the rigours of training and of practice can disconnect these professionals from their compassionate selves. Compassion must be nurtured. Maintaining a sense of connection with chronic pain patients is challenging given their emotional needs. Compassion burn-out may happen and be caused by 'medical vampirism'. A more 'new-age' vision would describe some patients as 'pretas', the tortured spirits of Hindu mythology who have been committed to the circle of perpetual hunger (6). Fear of compassion burn-out may, thus, limit commitment. As stated by a general practitioner about fibromyalgia, "I think the bottom line is no one really wants to look at it. It is a lot of work. It is very unrewarding; you don't see any concrete results. It's always like a constant decline so it becomes very unsatisfactory as a result" (1).

Technology has also had a negative effect on the humanistic provision of care at a time when we can do so much more in the cure of

diseases. As detective stories have evolved from *Sherlock Holmes* or *Hercules Poirot* solving crimes by listening and picking up clues, to modern television detectives asking for DNA-testing, medicine can no longer be perceived as a laying-on of hands. Now, it is a physician reading signals from a computer or speaking across an expanse of desk about laboratory results. However, this modern day technological hero may still face a frightened patient in need of human comforting and touch. Technology is often experienced as an invasion and dehumanizing (7). Patients and physicians increasingly feel rejected by one another and, perhaps as a consequence, justified or unjustified malpractice claims are soaring.

The effect on caring of efforts to control the spiralling costs of health care in the midst of the present economic crisis has also been mentioned in the literature. Economists and policy planners have proposed that patient care should be industrialized and standardized (8). A new language has emerged and been widely adopted where patients have become 'clients', 'customers' or 'consumers', and doctors and nurses 'providers'. Yet, the word 'patient' came from '*patiens*', meaning suffering or bearing an affliction. Doctor came from '*docere*' or teaching, and nurse from '*nutrire*' or nurture. As a profession, to preserve human values in health care, we must return to this traditional language and vision of compassionate medical care seeking to relieve pain and suffering (8). Medicine is both a science and an art. Paracelsus has said that the basic principle of medicine is love.

Thus, it is heartening to see that in these fast-changing times of increased fiscal responsibility in the provision of health care, Canadian values of fairness and compassion still hold and that health care professionals still seek to provide incentive for decision makers. This was demonstrated in a recent poll released by the Canadian Medical Association and in a recent set of principles put forward by both national associations of nurses and doctors, which stressed the need for patient-centred care and increased accountability (9). In a recent message, the CEO of the Royal College of Physicians and Surgeons of Canada urged physicians and health care leaders to lobby their local member of parliament for the federal government to take a more active role in health and health care renewal (10). We should not, at this point, forget the role of "caring", empathy, and compassion in the "best care for all" recommended in the CEO's message.

In conclusion, limitations in knowledge and skills have been described in the approach to chronic pain patients (1). As policy makers engage in the renewal maelstrom of the Canadian health care system, we must put forward the needs of patients in pain and the "devastating effects of this whole-person experience" (2). We must raise awareness about the consequences of the decisions of policy makers on our most vulnerable patients who need compassionate care. We must, as stated by the CEO of the Royal College, lobby to bring forward a vision of "the best health" and "the best care for all" (10).

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REFERENCES

1. Hayes SM, Myhal G, Thornton JF, et al. Fibromyalgia and the therapeutic relationship: Where uncertainty meets attitude. *Pain Res Manage* 2010;15:385-91.
 2. Ferrell B. Ethical perspective on pain and suffering. *Pain Manag Nurs* 2005;3:83-90.
 3. Farley M. Compassionate respect: A feminist approach to medical ethics and other questions. Madeleva Lecture on Spirituality. Mahwah: Paulist Press, 2002.
 4. Pizzo PA, Clark N. Alleviating Suffering 101 – Pain Relief in the United States. *N Engl J Med* 2012;3:197-8.
 5. Covey SR, Merrill AR, Merrill RR. *Priorité aux priorités*. New York: Simon and Shuster, 1995:294.
 6. Lowenthal M, Short L. *Opening the Heart to Compassion*. Vermont: Charles E Truttle and Company, 1993:79
 7. Rakel RE. Compassion and the art of family medicine: From Osler to Oprah. *J Am Board Fam Med* 2000;13:6.
 8. Hartzband P, Groopman J. The new language of medicine. *N Engl J Med* 2011;15:1372-3.
 9. Haggie J, Shmian J. The Patient Comes First. *The National Post*, January 10, 2012.
 10. Padmos A. A National Vision of Health Care Needs Leadership. A Message from the CEO, 2012. <www.royalcollege.ca> (Accessed January 28, 2012).
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