Of Healing and Human Suffering

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"I don't know why Ms. Jones keeps coming back to clinic, I don't do anything for her," stated the second-year family medicine resident. "She has complained of headaches, abdominal pain, and fatigue during the last 6 months, but physical examination has been unrevealing, and all laboratory tests, upper GI series, and gastroscopy were also negative. After I described her to you last month, I took your advice and asked about her family and social history."

"She is an unhappy woman who has lived a difficult life. She was the oldest of three children; her mother died of cancer when she was 8 years old, and her father was alcoholic. She had few memories of any parental expression of affection toward her. Her father was also physically abusive to her during her teenage years. She's 42 years old and has not had any close male relationships, has no close friends, and works in a temporary secretarial service. She has no health insurance; when I suggested counseling, she said she couldn't afford it. Ms. Jones always tells me how miserable she is because of her symptoms. I keep feeling as though I'm missing something. When I see her name on my schedule, my heart sinks and I feel overwhelmed."

The resident's recitation seems all too common these days, even though unhappy patients like Ms. Jones have always been overrepresented in physician schedules. With the advances of modern medicine, physicians often feel that unless they can prescribe a specific therapy for a patient's problem, they are not doing anything for the patient. Trained in the rigors of scientific therapeutics during medical school, physicians reflexively consider real therapies to be specific therapies. Yet the distinction between specific and nonspecific aspects of medical treatment becomes less clear with close scrutiny.[1] Patients are treated in the clinic or hospital, not in the laboratory. The difference between these settings must be bridged by the physician-patient relationship if therapies proved effective in the laboratory or during controlled trials are to work for real patients.

That these principles are as true for medical disorders as they are for psychiatric disorders perhaps accounts for such marked differences between efficacy trials, ie, the effect of specific treatments under ideal conditions in contrast to studying the same treatments in practice settings (the effectiveness of treatments). In efficacy studies patients with comorbid medical or psychiatric conditions are often excluded. Patients are seen more frequently during the trials, and a great deal of effort is spent educating the patient and ensuring adherence to treatment regimens. In everyday practice, process factors between physician and patient, such as the ability to establish rapport, to assess patient attitudes, beliefs, and worries, and to negotiate physician-patient differences in beliefs and expectations, have a powerful effect on patient satisfaction and adherence to medical care.[2] That nonadherence to medication regimens occurs in approximately 40 to 50 percent of patients with chronic medical illness suggests that these nonspecific aspects of medical care might not be well addressed.

Historical Perspective

Modern medicine has evolved from healing rituals that were embedded in specific spiritual, social, and cultural contexts. Historically patients viewed the shaman, healer, or physician as a person with esoteric knowledge gained through closeness to nature or one or more deities. Thus, healing rituals often involved prayers or sacrifices or ways of exorcising evil spirits from the body and mind. The healer had special knowledge of these ceremonies and often invoked the patient's larger family and social ties in the healing rituals. Disease and distress were not strongly distin-

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guished, with both seen as the product of disrupted important relationships, including family members and gods.[3] Shamanistic therapies were directed toward restoration of disrupted relationships and had only indirect effects on physiology.

The advent of medications with specific pharmacologic effects has gradually increased the power of modern medicine and decreased respect for spiritual, personal, and social aspects of healing. In fact, we now define the therapeutic power of medications in opposition to the power of the therapeutic relationship.[4] New pharmacologic therapies must prove their power through comparison with supportive visits and placebo treatment. Only those therapeutic effects produced in excess of what can be achieved with a therapeutic relationship and inert therapy are accepted as scientifically valid. Physicians deliver scientifically validated therapies, but one connotation inherent in the randomized placebo-controlled trial is that the physician-patient relationship is a nonessential and unscientific part of the therapy.

Physicians have traditionally measured the efficacy of treatment by the effect on the physiology of the patient, such as decreased blood glucose levels in the diabetic patient treated with insulin. Patients view quality and effectiveness of treatment more broadly and include the effect of treatment on their social, vocational, and marital functioning, as well as on the specific symptoms that brought them to the physician.[5] Studies have determined that the different variables patients and physicians use to decide whether a treatment is effective often lead to patient-physician discrepancies in whether they consider a treatment to be successful.[6] The Food and Drug Administration has in recent years begun to require treatment trials to include quality-of-life variables to determine the overall success of treatment.

Modern Medicine: The Healing Perspective

In modern medicine, other professionals, such as nurses or social workers, handle the personal and social changes caused by a disease or its treatment. Terminally ill patients receive care in hospice programs, and religious leaders provide pastoral services in hospitals. Modern-day physicians only rarely make home visits, which often provide invaluable information about the social, economic, and familial contexts of the patient. The exclusive focus of physicians on disease, having other professionals provide spiritual, social, family, vocational, and end-of-life care, has tended to remove the physician's attention from the patient's social milieu. With the exception of the field of family medicine, medical disciplines approach the individual as the unit of treatment, and the importance of the relationship of broken familial and social ties (as occur with divorce, grief, forced emigration) and economic hardship to the development of symptoms and medical illness is often overlooked. Moreover, the movement of medicine in the United States to a managed care model, which attempts to match specific economic coverage with specific medical conditions, reflects our cultural bias that values the technology and science of medicine over the nonspecific healing power of the physician-patient relationship.

Despite the movement of modern medicine away from the spiritual and social aspects of healing, many problems a primary care physician encounters daily result from human misery (somatic symptoms resulting from stress, depression, or anxiety) or are embedded in human misery and attempts to cope with unhappiness (maladaptive behaviors such as smoking, drinking, lack of safe sex, obesity). In recent years, modern medicine has even developed specific pharmacologic agents to treat some of this suffering, such as antidepressant medications, but there still exists a great deal of human misery, sorrow, distress, and unhappiness for which we will never have specific treatments. The growth of the counseling industry in the United States could be an adaptive response to modern medicine's reluctance to value the nonspecific healing aspects of the physician-patient relationship. It certainly also reflects an alternative way to cope with human pain in a time when fewer people are attached to religion.

The Physician's Role: Care Versus Cure

What is the role of modern-day physicians who take care of patients seeking help for the many reasons patients have come to healers for thousands of years, ie, palliation of their everyday misery by going through the healing ritual? Today this ritual involves patients shedding their clothes and putting on a hospital gown (increasing one's vulnerability), telling the story of their symptoms, having the physician "lay on hands" to examine them physically, and, finally, having the physician negotiate a diagnosis and treatment with them.

The ritual also involves caring, support, respect, and a nonjudgmental attitude from the physician.

Patient satisfaction has been shown to be associated with adherence to medication and lifestyle changes (dietary changes, exercise, and decreasing everyday stress), adaptation to aversive symptoms, and maintenance of quality of life.[7,8] For patients who have a chronic medical illness, the quality of the physician-patient relationship often plays a powerful nonspecific role in patient satisfaction with care. The healing relationship between physician and patient can also play an important role in alleviating symptoms and preventing patient demoralization and depression secondary to chronic medical illness. The placebo is arguably the physical symbol of the power of the physician-patient relationship to alter physiology. Placebo treatments have been shown to be powerful therapies for a wide variety of medical conditions.[9]

Michael Balint, who led groups of experienced general practice physicians gathering to discuss difficult patient encounters, often stated that among the main discoveries of the group was that many patients were seeking a "dosage of the doctor,"[10] the care inherent in the healing relationship. At times this patient behavior led to problems in the physician-patient relationship, as patients' needs were often not clearly communicated, and the unhappy and anxious patients used somatic symptoms as their ticket of admission to the clinic. This somatic symptom, a symbol of the unhappiness in their lives, was unconsciously used by patients seeking support and care when distressed. In many instances the physicians would keep trying to rule out all medical problems, gradually feeling increasing frustration and impotence as the multiple examinations proved futile. Shifting the focus to the stress in patients' lives sometimes helped, but just as often recognition of the complaints as a metaphor for the patient's misery and unhappiness led to a change in the physicians. The physicians began to have more empathy for the difficult circumstances in the patient's life and to recognize the symptoms as indirect ways of attempting to reach out for caring and support.

A resident in family medicine recently described a shift in attitude about a patient who complained of 5 years of back pain and kept demanding that the physician cure the pain. The physician began to understand that the patient had been chronically unhappy much of her life and was experiencing a great deal of stress because of the substance abuse problems of her two grown children. "What helped me with this patient was to realize I didn't have to fix the problem. I began to empathize with the patient's misery with statements such as, "I know you are in pain, and if I could take it all away, I would do it in a minute. Unfortunately, there is no cure for many types of chronic pain, but you and I can continue to work together to try some things to help you live with it as best as possible." With the focus on cure deemphasized, the continuing patient regular visits began more and more to consist of supportive counseling around the patient's family problems and the meaning of those problems to her.

Physicians tend to be active problem solvers who derive self-esteem from fixing problems. This coping style is synergistic with many acute problems patients bring to the physicians. Much human misery and pain, however, needs to be approached using a palliative, not a curative, model, but many patients in chronic emotional pain either seek care from physicians for physical symptoms or have unrealistic notions of a physician's power to help relieve their emotional pain. Furthermore, physicians can perceive chronic misery as akin to acute anxiety or depression, which might be cured with medication or specific therapy.

Physicians often feel progressively impotent as diagnostic tests prove negative and therapeutic trials of medication are ineffective, engendering frustration and anger that can increase linearly with the diagnostic and treatment failures. These emotions can be cues to the patient's misery and emotional pain, which is the correct diagnosis. Therapy based on care, not cure, can then remove the burden from the physician's shoulders and enable a return to proper therapeutic empathy and an effective physician-patient relationship. The ability to allow patients to talk about their life problems and life experience with a supportive nonjudgmental person is itself a powerful healing modality. Most psychotherapy trials have found that the best predictor of treatment success is not the specific therapeutic technique, but the patients' perception of the strength of the physician-patient alliance.[11] Modern medicine must not lose sight of the power and importance of this ancient alliance in its quest for scientific active treatments.

References

1. Shepherd M, Sartorius N, editors. Non-specific aspects of treatment. Toronto and Lewiston, NY: Hans Huber, 1989.
2. McCann DP, Blossom HJ. The physician as a patient educator. From theory to practice. West J Med 1990;153:44-9.
3. Levi-Strauss C. The effectiveness of symbols. In: Structural anthropology. Chicago: University of Chicago Press, 1983.
4. Sullivan M. Placebo controls and epistemic controls in orthodox medicine. J Med Phil 1993;13:213-31.
5. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med 1978;88: 251-8.
6. Katon W, Kleinman A. A biopsychosocial approach to surgical evaluation and outcome. West J Med 1980;133:9-14.
7. Joyce CRB. Non-specific aspects of treatment from the point of view of a clinical pharmacologist. In: Shepherd M, Sartorius N, editors. Non-specific aspects of treatment. Toronto and Lewiston, NY: Hans Huber, 1989:57-94.
8. Brody DS, Miller SM, Lerman CE, Smith DG, Lazaro CG, Blum MJ. The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. Med Care 1989;27:1027-35.
9. Turner JA, Deyo RA, Loeser JD, Von Korff M, Fordyce WE. The importance of placebo effects in pain treatment and research. JAMA 1994;271:1609-14.
10. Balint M. The doctor, his patient, and the illness. New York: International Universities Press, 1957.
11. Frank J. Non-specific aspects of treatment: the viewpoint of a psychotherapist. In: Shepard M, Sartorius N, editors. Non-specific aspects of treatment. Toronto and Lewiston, NY: Hans Huber, 1989:95-108.