Is Suffering the Enemy?

by Richard B. Gunderman

The relief of suffering is the great goal of medicine. That physicians give up on suffering when they can do nothing about the underlying condition is one of the contemporary criticisms of medicine. Yet even in irremediable suffering there is something noble, to which physicians should attend.

In sorrow shall you bring forth children.
—Genesis 3.16

Pain is ubiquitous in medical practice. In ambulatory medicine, headache and backache are two of the most frequent presenting complaints. Confronting pain, contemporary physicians wield a vast armamentarium by which to provide relief, from over-the-counter pain relievers to intravenously administered opiate-receptor agonists that mimic the brain’s endogenous painkillers.

Despite our burgeoning understanding of the physiology and pharmacology of pain, however, we physicians are routinely chided for our failure to provide adequate pain relief. Undertreatment of pain, presumably grounded in ignorance and a fear of addiction to controlled substances, haunts many chronic pain patients and poses a vexing problem in the care of the terminally ill. It is not so much dying that many of these patients fear, but dying in pain.

Anyone who has ever suffered from a nagging toothache, menstrual cramps, migraine headache, or painful spasms in the lower back—let alone the pain of skeletal metastases or myocardial infarction—knows the havoc pain can wreak on the human psyche. In the space of mere seconds, pain can so quickly invade and dominate the psychic landscape that no room is left to attend to anything else. It can be extremely gratifying to provide symptomatic relief for such a patient. Among the most frustrating cases in medicine are those in which pain is wrecking a patient’s life but adequate relief cannot be provided, in part because no anatomic explanation for the pain is apparent.

Yet should we regard pain always as an unadulterated evil, to be avoided and relieved wherever possible? I recently spoke with a group of precocious fifth graders about the development of anesthesia and the conquest of surgical pain. The fifth graders began to pose some rather probing questions. First they wanted to know what causes pain. We quickly produced a
list of things that can be painful. We noticed that sometimes the source of the pain comes from outside, such as a traumatic laceration, and sometimes the source of pain lies within, such as an infected tooth. Next they wanted to know why we feel pain. This precipitated a brief discussion of the neurology of pain.

“But why do we feel pain?” the students insisted. It soon became apparent that they were posing a much deeper question. Taking into account how disturbing and even destructive pain can be, they wanted to know why we even possess the capacity to experience pain in the first place. “Wouldn't the world be a better place if there were no pain?” they asked.

I described to the students a few cases I had encountered during my career of a remarkable condition called congenital insensitivity to pain. Patients with this condition do not sense pain, or at least manifest a remarkable indifference to it. “What do you suppose happened to these people?” I asked the students. “For example, what would happen to such a child if he broke his toe playing basketball?” They pointed out that, despite the fact that you could amaze your friends by sticking pins through your arms and the like, being pain-proof wouldn't necessarily be a good thing. I described the permanent skeletal deformities that often result in such patients because of their tendency to ignore injuries that would immediately stop the rest of us from using the wounded part.

Then some of the students mentioned the importance of feelings of privation, such as hunger and thirst, which, though not the same as pain, seem to be closely related. If people were undisturbed by the fact that they hadn't eaten in a very long time, or that they were becoming severely dehydrated, they probably wouldn't survive for very long. Soon we came to the conclusion that, while it is unfortunate that any patient should suffer, and doctors and nurses should continue to try to relieve suffering, we wouldn't want to do away altogether with the human liability to pain. As I gathered my slides to go, one of the students captured it nicely: “Without pain, we wouldn't be able to live.”

Reflecting on this remarkable discussion over the ensuing weeks, I realized that the fifth graders had taught me something unexpected. My knee-jerk medical response to suffering—namely, to identify its source and attempt to remove or suppress it—wasn't always on the mark. The discussion reminded me of the nineteenth-century controversy surrounding the introduction of inhalation anesthesia in childbirth. Struck by the “unnaturalness” of painless childbirth, critics of anesthesia pointed to the Biblical curse leveled at Eve on her expulsion from the Garden of Eden: “In sorrow shall you bring forth children.” These divine words, they argued, provided a clear indication that childbirth was intended to be painful, and that efforts to provide artificial relief were an offense against the express will of God. To this the great British physician James Simpson, who knew his Bible perhaps even better than his opponents, retorted that God clearly endorsed anesthesia. After all, before he removed from Adam the rib from which he fashioned Eve, he put his patient to sleep. Far from forbidding pain relief, God himself had served as the world's first anesthetist.

Are the professional descendants of James Simpson entirely on the mark? On the one hand, the suffering of others is not a morally neutral matter. To accept another's suffering without concern is to be guilty of indifference. To take delight in another's suffering is to be guilty of cruelty. Suffering is not something we can welcome, and we would probably condemn anyone who sought to promote it. And yet can we really claim that suffering is all bad? Would we condemn the tragedies of Sophocles and Shakespeare, which invite us to share in suffering aplenty?

What of the patients and families who look back on periods of suffering with a sense that they learned something through the course of their travels? What of the countless people who have emerged from suffering with their outlook on life transformed—the sense that, by virtue of having endured, they are actually leading more meaningful lives? Is this merely the self-serving reflex of the Pollyannas and Panglosses of this world, insistently finding some silver lining in every cloud? Or is the larger truth to be found in the words of Aeschylus: “It is only through suffer-

Is the larger truth to be found in the words of Aeschylus: “It is only through suffering that we achieve wisdom”? (Agamemnon, ll. 177-78)

Far from condemning the likes of Sophocles and Shakespeare, it seems to me, caregivers should seek them out.

The Nature of Suffering

Over the past century and a half, the vast territory of suffering has undergone a series of conquests. The pain of the scalpel, for example, has been largely subdued. But many aspects of suffering have proven more resistant. Medications have not assuaged the helplessness and frustration that accompany stroke and head trauma. Nor have they subdued the dementias, most notably Alzheimer's disease, which rob patients not only of their intellectual and motor capabilities but of their very identities. Pain is an abnormal presence, something that can be combated and suppressed. With the absences of disability, however, there is no such external foe to be reckoned with.

One of the most disturbing aspects of the loss of function is the assault on
Suffering as the Enemy

Suffering reminds us of the fragility of our mortal coil. We have an intense desire to alleviate suffering, yet the aspect of his suffering that tortured him most, leading him to rue the day he was born, was his inability to find any justification for what befell him. In the contradiction between divine justice and his own abject misery, he feels as though the fabric of the universe is being rent apart. Through Job we learn that it is not suffering that destroys people, but suffering without meaning.

The Medical Response

Contemporary medicine’s ability to “fix” certain types of suffering has produced a gradual shift in caregivers’ attention toward those types of suffering that are most fixable. Physicians tend to feel most competent when addressing conditions that they can understand anatomically, physiologically, and biochemically—the conditions for which pharmacological interventions are most readily available. Other aspects of suffering, however, are not so easy to understand or treat biologically, and as a result, many caregivers feel inept at dealing with them. This sense of incompetence can breed avoidance, and physicians soon find themselves referring patients whose suffering cannot be managed biologically to psychologists, social workers, and chaplains. Larger issues of human suffering—dependency, guilt, anger, isolation, the loss of the pleasures and fulfillment that make life worth living—are regarded by many physicians as outside medicine’s core competency. Patients who cry out for help and support in dealing with such difficulties may find that their entreaties fall on deaf ears.

The fact that an injury is unfixable does not necessarily give us license to give up on it. We need to expand our cognitive range. Human experience is an intricate phenomenon, and its myriad facets cannot be adequately comprehended from any single vantage point. Molecular biology cannot represent the only relevant form of human discourse, for it is impossible to render all that physicians know or need to know in molecular terms.

Likewise, the contemporary pharmacopeia does not contain every response to suffering that physicians need to be capable of offering their patients.

Confronted with suffering, the caregiver’s goal is not merely to deaden pain. Too often, efforts to deaden pain end up deadening awareness as well. I can recall a number of terminally ill patients who, much to the surprise of their health care team, requested a reduction in the dosage of their painkillers because the drugs were making them feel groggy or slow or just plain “stupid.” Most patients want relief from pain, but they also want to remain themselves.

The effort to excise suffering pharmacologically sometimes denigrates the whole experience. “Oh, your spouse just died?” we seem to say. “Let me give you a pill for that.” Signal life events such as serious illness and the death of a loved one are part of the human condition and should be treated more as burdens to bear and struggle with than as irritations to be cast off and ignored. To attempt to make them simply go away is to imply that the person confronting them might as well go away. Caring for patients doesn’t always mean relieving their suffering; sometimes it means sharing their suffering, helping them to shoulder the burden.

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Have you ever watched television in an intensive care unit? Confronting the travails of serious illness, one can suddenly see the products advertised for the distractions they really are. There are far more meaningful goods to be found. Given the chance, patients and families confronting impending death talk not about their automobiles, their houses, or their bank accounts, but about their friends and family, and the times they have shared together. They dwell not on what they have coveted, but on what they have loved.

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to trivialize another person’s experience, to diminish its scope and lessen its significance. It is to falsify and invalidate the other person as a person. Such deception quickly infects and corrupts the entire doctor-patient relationship, making it impossible for the caregiver to discern what is truly best for the patient, and rendering the patient unable truly to trust the caregiver. Each is holding back, each navigating by a false map, each misapprehending where the other is coming from.

**Attending to What We Cannot Correct**

The fifth graders were on to something, a paradox of sorts. The relief of suffering is one of life’s noblest callings, in which health professionals are privileged to participate. In caring for the sick, we seek to lighten their afflictions, and in so doing we labor on the side of the angels. Yet it would be wrong to say that virtue consists in dodging suffering. To be sure, there would be a certain artfulness in this dodging, but the art of caring, which is the art of “humaning,” consists of something more. Ironically, it is sometimes only in the midst of sorrow that we bring forth the greatest and most inspired truth we have to share. Our curse is, in a sense, also our birthright.

Just as it would be self-defeating to seek to craft for ourselves a life devoid of all possibility of suffering, we should protect those for whom we care from similar harm. The suffering that we cannot relieve may be every bit as deserving of our attention, perhaps even more so, than the suffering that our magic bullets can vanquish. To make suffering a purely technical problem in order that we may abort it is, in effect, to deny and trivialize life itself. Far from denying suffering by treating only the pain, we should acknowledge it, and even, in a certain sense, embrace it. To inflict suffering would be cruelty, but to ignore or deny or trivialize it is no less inhumane, for it blinds us to love, and stifles the human calling to become wiser than we are.