"If you think it hurts now . . ."

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Experience

Expérience

Dale Needham is in the Class of '98 at McMaster University. As part of his training, he recently completed an academic-enrichment year that focused on HIV research with the London School of Hygiene and Tropical Medicine in Lusaka, Zambia, and the British Columbia Centre for Excellence in HIV/AIDS at St. Paul's Hospital, Vancouver.

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I blinked several times, looked away, and briefly thought of other things. The elderly woman in the chair across from me was accompanied by her husband and son. They were a rural family, and the mother and father reminded me of my own grandparents. They hadn't been to the immunodeficiency clinic for more than a year and seemed overwhelmed by their surroundings.

Perhaps the visit made her HIV infection seem more real. Perhaps they found the recent research and advances in HIV therapy puzzling. They were also dealing with the many complexities surrounding HIV infection in an elderly woman in rural British Columbia.

As I learned more about the woman, I better understood her situation. Her confusion may have been caused by the role health care had played in her life: successful surgical intervention had reduced her morbidity while the blood transfusion she received during it had left her infected with a deadly virus.

That day in the clinic I had no difficulty appreciating the family's feelings because these people seemed so familiar. Perhaps my greatest difficulty was confronting my own feelings without being overwhelmed by them, at least not in front of the patient and her family.

After seeing this woman, I handled the initial consultation with a new patient. Do you have sex with men, women, or both? Do you have unprotected sex? Oral or anal? Do you visit prostitutes? How often? Are you sexually active now? Do you have a regular partner? Have you ever used intravenous drugs? Heroin? Cocaine? Both? Do you currently use IV drugs? Are you using right now? Have you shared your HIV status with anyone? Does your family know you are gay? Is there anyone to provide emotional support?

Patients are expected to share personal details like these with a complete stranger during their initial clinical encounter in the immunodeficiency clinic. The information they share is so private that no one but a physician is ever likely to hear it.

These very personal details paint vivid pictures, and even though the questions and answers become routine the stories told come to life over a series of clinic visits. The insights they provide make even strange situations seem familiar.

When the tall aboriginal man entered the examination room in handcuffs and leg shackles, I gained understanding of his life as an intravenous drug user, prison inmate and resident of an Indian reservation. He spoke about his drug addiction, his problem with anger control, his imprisonment and the realities of returning to his remote reserve as "patient zero."

I quickly learned that one can't judge others by appearances or circumstances: this apparently threatening man was more like a child at Christmas than a violent offender. He eagerly sought to learn all he could about the natural history and treatment of his disease.

Is this familiarity with patients a good thing? Must I shut it out if I want to develop into a "seasoned clinician"? Or do I let it in, hoping to understand the swirling circle of pain and confusion my patients are experiencing?

My father certainly felt shut out when the radiation oncologist said: "If you think it hurts now, just wait." My father had asked him for relief from severe odynophagia during his course of radiation therapy of the head and neck.

Seven years ago, that experience played a key part in my considered decision to leave chartered accountancy, which I enjoyed and excelled at, to once again become a student and aspire to become a physician. Seeing my father in pain may have made me more sensitive to patients' needs. This need for a patient's perspec-

tive in areas of serious illness certainly attracted me to HIV medicine.

But empathy is exhausting. This message was most clear when I did AIDS-related research in Zambia. I sat across the table facing a woman who looked tired and wasted because of her TB and HIV. She spoke very softly, making it seem that all her available energy was being consumed by our conversation. Her sister was also infected with TB and HIV. They had been caring for their mother at home when she died of TB, so their follow-up infection seemed almost inevitable because of their immunosuppression. I began telling the young woman about the free TB medications we could provide.

I cried as I wrote about the encounter in my journal. Empathizing with patients is difficult sometimes.

As we talked, I began learning more about her life. "You have to suffer sometimes," she said. "No lunch, no breakfast. We only have supper sometimes. We cook some porridge for those little ones [the small children in this extended family]."

She explained that her father was the only family member working. "We did not have breakfast and I don't think there will be food for lunch because he has not left money. He says he does not have money. Maybe he will come home around 16 hours (4 pm) and then we will have supper."

With the death of her mother, the family had to leave the home provided by her employer. They now live with her grandfather, but she tells me that this is not easy. "If we eat vegetables for 2 days, my grandfather gets angry and says we must go so he can find someone who can pay better rent. But we have nowhere to go."

I felt foolish. What good would free TB medicines do for someone whose basic needs for food and shelter are much more immediate? What was I offering her that was really helpful? After I ate dinner and sat alone in my apartment that night I cried as I wrote about the encounter in my journal. Empathizing with patients is difficult sometimes.

But how can I strike the right balance between clinically treating, empathizing with, caring for and suffering alongside patients? "To appreciate the patients' feelings doctors must be willing to confront their own feelings," the late Dr. Mark Longhurst wrote in *CMAJ* (1980;123:597-8.). "They must not be overwhelmed by them."

I believe that appreciating patients' feelings and conveying this empathy to them is a critical part of the therapeutic process. This was clearly illustrated as I observed my father's relationship with his radiation oncologist — the feelings of hopelessness Dad drew from this relationship were far from therapeutic. Is this emotional part of the therapeutic process a task we are willing to undertake, or is writing a prescription an easier way to fulfil the physician's role?

Confronting personal feelings in order to appreciate patients' concerns requires reflection rather than robotic history taking and physical examination. "No sooner does one dissociate one's personal self from the clinical situation," wrote Stein, "than one makes the patient likewise into an inanimate object." (Stein H. What is therapeutic in clinical relationships? *Fam Med* 1985;17:188-94.)

Reflecting on medicine through quiet introspection is helpful. I do this when I let my mind wander over patient encounters as I walk home from a day in the clinic. I think about how different life is for the aboriginal man I saw, handcuffed and shackled, earlier today. The true realities of living with HIV in Zambia, something I often ignored when interviewing a patient, came to me while I washed my clothes by hand. I had time to reflect on these patients and confront my own feelings of being a "have" in a world of "have nots."

Writing also aids reflection. My feelings of impotence that came from dealing with the young Zambian sisters with TB and HIV were much easier to cope with when I tried to write about that patient encounter. Talking to a trusted friend can have the same effect. There are many ways to reflect on medicine — we simply have to recognize that it is necessary and make time for it.

However, it is not easy to confront personal feelings. Balance must be achieved if we are to avoid being overwhelmed and discouraged by the things we witness. Even if we are overwhelmed, we might find that this personal experience provides some unexpected opportunities for personal growth.

As a medical student, I may not possess the clinical experience that will provide the appropriate perspective on this issue. However, inexperience does help me to understand the patient's perspective and to look at medicine with unjaded eyes. Only time will tell which perspective is better.

I do know that it will be time for me to stop practising medicine when I hear myself saying, "If you think it hurts now, just wait."

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