Alberta Doctors' Digest

Guest article: Medicine’s impossible compassion burden

We all remember going to our medical school interview, primed with all the right answers. “Why medicine?” “I want to help people.” Don’t say that! There are many ways to help people in this world. Waste management, spiritual guidance, providing families with a new mortgage, and designing and building bridges or cars all help people.

But medicine is notably different. Indeed, in physicianhood, we help people. Face to face. In sickness, decline and death. In the deepest darkest illnesses to the elation of healing, physicians are healers. We walk into the illness with the patient, as Virgil to Dante. And as we all know, life is not an illness that can be won. One patient healed; a new one arrives ill. Someone we’ve brought to health turns and dies.

Death is inevitable. Formerly we accepted this and soldiered on, ready to take the lessons of science and life into our next patient relationship. Increasingly now there grows a gap. In modern medicine, scientism seeks to heal the illness, not the patient. Focusing on numbers, metrics, drugs and disease entities, the physician faces an inability to compassionately and mercifully care for the whole person.

Western medicine has valiantly battled the human condition. Medical evidence continues to grow on a daily basis. New treatments abound. Procedures improve. Cancer treatments evolve. Vaccines are created in days. Our knowledge of the body is now supplemented with smartphones and UpToDate subscriptions. We are educated and hopefully wise guides along the ever-changing path of medical care ... but are we physicians?

In this hyper-evidenced, post-enlightenment, post-modern medical model, we are less and less so. We are distancing ourselves from the compassion that led us all here. And as this split widens, a compassion burden grows, fuelled by an increasing dehumanization of illness and a global “connectedness” that has removed limits on how much one can attempt to give of oneself. As we lose the means to limit how much compassion one can be asked to feel, with minimal opportunity to actually practice the act of compassion, physicianhood in the Western world is cracking.

As a physician, how do we help someone? Is it in our clinical exam? The routine labs or the FIT or the 50-year-old screening colonoscope? Is care a mammogram? A diagnosis? The provision of a bad result but the consult booked and bloodwork planned, all covered in 10 minutes or less? We have guidelines for every disease. We have hospitals keeping tabs on the most minute expense, presented as an obvious and ever-present line item in the heavily bureaucratized patient chart. Administrators want patients to get better faster – and with fewer resources.

As patients, we attend health care institutions more frequently. Misplaced anxiety drives patients to flock to the doctor’s office or emergency room for minor problems: the “worried well.” We want more out of life. We tear our ACL hucking a cliff or chasing the ball, and we expect to be back to sport next week. We want to keep our vices, but never suffer. Isn’t there a pill for my gout and obesity? It’s easier than self-improvement. We

live a life producing chronic disease but never want to die. Can't we just medicate it? Health improves; human longevity stretches. And, in ever more rarely facing death in our daily lives, we come to fear death. No problem ... we have a pill for that too.

We physicians enter the profession with eyes half closed. We do want to help people. Our white coat ceremonies celebrate a centuries-old tradition derived from a millennia-old practice. We aspire to improve the world, one patient at a time. It is a time of great excitement. However, in the face of mounting educational goals, myriad CanMEDS roles to fill and a clinical teaching force increasingly burnt out and cynical, the excitement soon wanes. We get tired, endlessly on call. We try to learn the pathology, physiology, anatomy, biology and biopsychosociology of each new illness. We are lucky to have electronic textbooks at our fingers and algorithms from every medical society.

So we dive deep on the science. Journals produce such a flood of information that every year a guideline needs reworking. Evidence conflicts and societies oppose each other's conclusions. The learner now needs to pick a camp. We start to divide, and our focus continues to creep into the tower of splintering medical knowledge. In this division of expertise, disease, body parts and systems is the root of the division of our physician selves. The seeds of discontent and cynicism are not just planted but floridly growing.

We all feel this growing dissonance. When we are running between exam rooms, up and down floors of a hospital, or from OR to OR as fast as humanly possible, we know we are missing something. We feel it when the demanding patient leaves us no quarter. We feel it when we don't have an answer to a mysterious illness. We feel it when we pay more of our income to keep our office doors open or to add a new machine or test or nurse at the clinic. That new drug needs monitoring, and if we don't keep our panel on 90% targets, the government funds won't flow. We answer increasingly to those who would demand anything and everything of us. And they have access to us in ever deeper ways. Our clinic income depends on non-expert, disengaged administrators. Our phones beep into our wireless earpieces. Our computers are opened to a litany of emails, unavoidably encountered as we log in to finish charting once the kids are in bed. Our tap is on full, but the pool only grows deeper.

We reach out to our online social groups. Too busy with patient care, we don't have time to stop and chat with our colleagues between patients or in the hallways. The charred black coffee machine and free pre-packaged hospital cookies of a lounge are replaced by a quick Starbucks pick up on the way to work (we don't even engage with the barista now; we just send the order on the app). Without our colleagues, we have no decent outlet to explore and process our shared experience. We no longer discuss the cases around our hospital. We lose our finger on the pulse of our place, losing the depth of perspective behind the individuals we see and care for. With the advent and explosion of social media, we are attempting to connect anew. Sadly, it is in the worst of ways.

The online community is not a community. When we connect online, we do not connect. There is an obvious chasm of physical space that is not bridged. This is not empty space. In this space exists the lost relationships of an unwired community. We first seek out our old and new friends. Then those with common experience. The SocMed bots stream the ideas we like back to us in varied forms. We create an echo chamber. We stare at a screen, deeply engaged but completely unaware of the person beside us. We don't have to navigate the space around us as we willfully and blindly walk through with our devices as safeguards. But walking alone.

Prior to the online age, interpersonal connection had a finite footprint. One had to see the person on the metro on the opposing seat. One had no LED-lit bedtime distraction;

suffer your company or fake sleeping (or a headache?). There was only so far one could travel before they had to engage: to ask directions, buy groceries, or even just politely smile while crossing paths. And while we could travel to some limited extent, we lived at home in a community.

What is a community? Until relatively recently, for the whole of humanity, a community was those physically around you. In the hospital this was the staff, nurses, physicians and patients with whom one interacted. At home it was the neighbourhood. One would have to chat with the neighbour and just come to terms with a difference (or start a feud?). Now, we can ignore any person problematically different enough just by turning to our online world.

Physical communities suffer, whether the restaurant table, the workplace, the park, the church or the sporting venue. We remain unchallenged to exist in the present physical space with all of the inconveniences and biases that might be foisted upon us. We lose the skills to cope, negotiate and sacrifice. We hear what we want to hear and disengage from the real physical world around us. And what are we hearing?

There are many messages of varied nature in the online physician communities, and most are overwhelmingly negative. Rage bubbles forth about inadequate pay and raises not meeting inflation – whatever statistically anomalous number that was decided that day. Anger at politicians seems universal. But mostly it is the cause de jour. There is no end of causes in the world. And the internet age has created an impossible task. How does one delimit one's causes? Extremely well-organized groups of very caring people bring forth the most terrible plights of humanity. What soul could not feel sympathy?

As physicians, we are innately compassionate and tend to have a focus on social and personal justice. This combination makes us excellent face-to-face practitioners and patient advocates ... when we take the time. When we don't, and we move online, these same characteristics make us terrible at moderating how much of ourselves we give, which is exponentially compoundable online. But the online world accidentally and callously weaponizes our senses of social justice and compassion against us.

The first problem is picking one cause. Hard to do. If we can even pick a single cause, then one sees the worst of the worst and feels the heartstrings tugged by well-crafted, highly targeted messages. This seemingly insurmountable problem can be fixed! But only with your help. Other physicians of similar nature are involved, people with whom we identify and feel commonality. With noble intentions we engage one another. But the problem has no limits. It is the potentially finite problem one might have seen in a community, but writ large as the global meta-narrative of that problem.

It is no longer just the local war vet whom everybody knows with the alcohol use disorder. It is all the alcoholics with post-traumatic stress disorder. It is not the elderly lady up the street who is housebound, desiring a visit. It is all the shut-in elderly. It is not just your son or daughter, still reeling from two years of missed school; it is a generation torn by COVID.

We see all of them. We try to understand them all. We feel for them. We have sympathy and attempt compassion.

But we do not complete compassion.

What is compassion? The Latin root "compati" means "to suffer with." It is not a feeling. It is an act. It requires an engagement. A real connection. Compassion denotes an

understanding of the human condition, a willingness to put ourselves in another's shoes, regardless of shared or variable experience, and to take on that burden of suffering. Compassion requires imagination, intuition, openness and ultimately love. Why would one bother to bear the suffering of another if not for love? To fully be a physician is not just to know the latest guidelines, tests, procedures and pathology; to be a physician is to sagely and carefully share these in a setting of compassion.

Compassion and mercy are oft used interchangeably. In the Christian biblical corpus, the Hebrew root has been translated as either word depending on which translation is used. While the two are inexorably intertwined, mercy can be thought of as the fruit of compassion in the alleviation of suffering. When we practice compassion as physicians, we also practice mercy. Even the act of listening to a story of an illness is an act of mercy itself. The sharing of one's story aids in the healing of the patient's essence.

Our willingness just to be there is the first step of healing mercy. The achievements of science have led us to be able to treat illness in amazing ways, but the patient and physician both still recognize that the relationship of healing is based in compassion and mercy. In an online world, where our compassion is amped to fever pitch without the ability to act in an embodied way, we lose the ability to complete acts of compassion and mercy.

"This change in the quality of space bears implications for practicing the virtue of mercy – a virtue that, in full, contains two parts. The first is the sensual grief over someone else's suffering, which requires the ability to recognize the particular suffering at hand. The second is volition action – that is, the willingness to act upon the suffering recognized by sharing in the burden if not healing the one who suffers."

While every issue we attend online may be important, we cannot complete these virtues of compassion and mercy. And when we see patients with a computer screen between us and a bean counter weighing our choices of treatment, we cannot be emotionally free to be fully compassionate. We may be able to eliminate the suffering and heal the patient's medical illness. But the patient's self may as yet remain incompletely healed. And the physician similarly may not feel the fullness of the healing act, in having not processed the grief, suffering or celebration with the patient. Our success as healers is unavailable as an individual unidirectional force. Fully healing necessitates a relationship. To find commonality in our human frailties and our resilience. "Communis". Community.

How we are defining our community is defining how we will act as physicians. In a pre-internet world, it was different. While we were aware of the global issues, we had limited exposure and availability to commit mind and body in full. From conferences and learning, we returned to our practices, which were naturally delimited by skills, patient load, familiar workplace staff and physical presence. The global issues out there slipped away as the rhythms of a contained practice and life took over in an unwired world. Our focus adjusted, sharpened by some learnings at the latest conference or guided by an awareness of a new matter arising. We returned to our patients, communities and families as physicians and people. We could act out our compassion in the meaningful daily interactions, living as a healer. We could practice mercy, a virtue that when given, builds the giver. Mercy and compassion, virtues born of love, grow in the giving. They cannot be held incomplete; when not given, they fade away, leaving a void.

In our hyperlinked society, we work hard to care about everything. It is easy to feel concern for the latest disaster or an ongoing refugee crisis a million miles away. That should pull our heart strings. There is no end of concerns in this world that need the

attention of good, hard-working and concerned people. But we cannot do everything. And in the process of attending these distant and insurmountable issues, two things happen. First, we erode our own presence in our physical community, focusing instead on the ether. Second, we lose our ability to act fully our compassion and mercy as physicians. We care deeply for the issues afflicting those in the world but rarely can we actually act meaningfully at that level. Inevitably, we must hit a wall. We are left holding the loose ends of our attempts at compassion out there, to turn and find nobody remaining beside us.

We are all feeling this loss. We see it in the vitriol that creeps rapidly into Facebook groups. In the rage of 280 Twitter characters. We feel it as we try to learn more and more to educate the vaccine resistant, only to find that knowledge didn't help. Hyper-connected to our peers, we frustratingly find deaf ears and division from the physical humans around us. A new discrimination insidiously forms in a seemingly noble and meaningful online existence. We become us and them. Our neighbour becomes our enemy, an abstract online avatar our friend and salvation. "Connected" our embodied self is alone. Our physician vocation is now tainted by an online world unreconciled to our very real environment.

It is time to turn our attention back to our physical communities. This starts by having compassion for ourselves and admitting our own suffering and dissatisfaction. Then, recalling the second most important rule, we must love our neighbours as ourselves. When we see a person as an "unvaccinated racist and misogynistic extremist," we cannot love or have compassion for that person. Our neighbour is not a viewpoint on gun control or abortion or vaccines. Focusing on these divisions first objectifies then dehumanizes real people. Regardless of these differences, our neighbour is a person just like us, seeking compassion, healing, mercy, acceptance and love.

We physicians should have a first-hand experience of this, treating all patients from all walks of life without judgement. We must not change care based on voting pattern, earning power or a bumper sticker. We must provide compassion for our patients as a healer. We try to provide mercy for their suffering. Done right, we become not just healers, but foundational and leading members of our communities. And we, as physicians, become whole.

Editor's notes:

(1) Compassion and mercy have a common root in the Hebrew word "racham". In the Hebrew language, the three-letter root is common to "rechem", meaning "womb". The root of compassion and mercy is a concept derived from the compassion a mother holds for the developing child in the womb.

(2) Leonardo J Delorenzo, *The conditions for Evangelizing our Youth, Evangelization and Culture*, Issue No 12, page 101

(3) The views, perspectives and opinions in this article are solely the author's and do not necessarily represent those of the AMA.

(4) Banner image credit: Gerd Altmann, Pixabay.com