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The Nature of Suffering and the Goals of Medicine

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Abstract

Article

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Letters

THE obligation of physicians to relieve human suffering stretches back into antiquity. Despite this fact, little attention is explicitly given to the problem of suffering in medical education, research, or practice. I will begin by focusing on a modern paradox: Even in the best settings and with the best physicians, it is not uncommon for suffering to occur not only during the course of a disease but also as a result of its treatment. To understand this paradox and its resolution requires an understanding of what suffering is and how it relates to medical care.

Consider this case: A 35-year-old sculptor with metastatic disease of the breast was treated by competent physicians employing advanced knowledge and technology and acting out of kindness and true concern. At every stage, the treatment as well as the disease was a source of suffering to her. She was uncertain and frightened about her future, but she could get little information from her physicians, and what she was told was not always the truth. She had been unaware, for example, that the irradiated breast would be so disfigured. After an oophorectomy and a regimen of medications, she became hirsute, obese, and devoid of libido. With tumor in the supraclavicular fossa, she lost strength in the hand that she had used in sculpturing, and she became profoundly depressed. She had a pathologic fracture of the femur, and treatment was delayed while her physicians openly disagreed about pinning her hip.

Each time her disease responded to therapy and her hope was rekindled, a new manifestation would appear. Thus, when a new course of chemotherapy was started, she was torn between a desire to live and the fear that allowing hope to emerge again would merely expose her to misery if the treatment failed. The nausea and vomiting from the chemotherapy were distressing, but no more so than the anticipation of hair loss. She feared the future. Each tomorrow was seen as heralding increased sickness, pain, or disability, never as the beginning of better times. She felt isolated because she was no longer like other people and could not do what other people did. She feared that her friends would stop visiting her. She was sure that she would die.

This young woman had severe pain and other physical symptoms that caused her suffering. But she also suffered from some threats that were social and from others that were personal and private. She suffered from the effects of the disease and its treatment on her appearance and abilities. She also suffered unremittingly from her perception of the future.

What can this case tell us about the ends of medicine and the relief of suffering? Three facts stand out: The first is that this woman's suffering was not confined to her physical symptoms. The second is that she suffered not only from her disease but also from its treatment. The third is that one could not anticipate what she would describe as a source of suffering; like other patients, she had to be asked. Some features of her condition she would call painful, upsetting, uncomfortable, and distressing, but not a source of suffering. In these characteristics her case was ordinary.

In discussing the matter of suffering with lay persons, I learned that they were shocked to discover that the problem of suffering was not directly addressed in medical education. My colleagues of a contemplative nature were surprised at how little they knew of the problem and how little thought they had given it, whereas medical students tended to be unsure of the relevance of the issue to their work.

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The relief of suffering, it would appear, is considered one of the primary ends of medicine by patients and lay persons, but not by the medical profession. As in the care of the dying, patients and their friends and families do not make a distinction between physical and nonphysical sources of suffering in the same way that doctors do.¹

A search of the medical and social-science literature did not help me in understanding what suffering is; the word "suffering" was most often coupled with the word "pain," as in "pain and suffering." (The data bases used were *Psychological Abstracts*, the *Citation Index*, and the *Index Medicus*.)

This phenomenon reflects a historically constrained and currently inadequate view of the ends of medicine. Medicine's traditional concern primarily for the body and for physical disease is well known, as are the widespread effects of the mind-body dichotomy on medical theory and practice. I believe that this dichotomy itself is a source of the paradoxical situation in which doctors cause suffering in their care of the sick. Today, as ideas about the separation of mind and body are called into question, physicians are concerning themselves with new aspects of the human condition. The profession of medicine is being pushed and pulled into new areas, both by its technology and by the demands of its patients. Attempting to understand what suffering is and how physicians might truly be devoted to its relief will require that medicine and its critics overcome the dichotomy between mind and body and the associated dichotomies between subjective and objective and between person and object.

In the remainder of this paper I am going to make three points. The first is that suffering is experienced by persons. In the separation between mind and body, the concept of the person, or personhood, has been associated with that of mind, spirit, and the subjective. However, as I will show, a person is not merely mind, merely spiritual, or only subjectively knowable. Personhood has many facets, and it is ignorance of them that actively contributes to patients' suffering. The understanding of the place of the person in human illness requires a rejection of the historical dualism of mind and body.

The second point derives from my interpretation of clinical observations: Suffering occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner. It follows, then, that although suffering often occurs in the presence of acute pain, shortness of breath, or other bodily symptoms, suffering extends beyond the physical. Most generally, suffering can be defined as the state of severe distress associated with events that threaten the intactness of the person.

The third point is that suffering can occur in relation to any aspect of the person, whether it is in the realm of social roles, group identification, the relation with self, body, or family, or the relation with a trans-personal, transcendent source of meaning. Below is a simplified description or "topology" of the constituents of personhood.

"PERSON" IS NOT "MIND"

The split between mind and body that has so deeply influenced our approach to medical care was proposed by Descartes to resolve certain philosophical issues. Moreover, Cartesian dualism made it possible for science to escape the control of the church by assigning the noncorporeal, spiritual realm to the church, leaving the physical world as the domain of science. In that religious age, "person," synonymous with "mind," was necessarily off limits to science.

Changes in the meaning of concepts like that of personhood occur with changes in society, while the word for the concept remains the same. This fact tends to obscure the depth of the transformations that have occurred between the 17th century and today. People simply *are* "persons" in this time, as in past times, and they have difficulty imagining that the term described something quite different in an earlier period when the concept was more constrained.

If the mind-body dichotomy results in assigning the body to medicine, and the person is not in that category, then the only remaining place for the person is in the category of mind. Where the mind is problematic (not identifiable in objective terms), its very reality diminishes for science, and so, too, does that of the person. Therefore, so long as the mind-body dichotomy is accepted, suffering is either subjective and thus not truly "real" — not within medicine's domain — or identified exclusively with bodily pain. Not only is such an identification misleading and distorting, for it depersonalizes the sick patient, but it is itself a source of suffering. It is not possible to treat sickness as something that happens solely to the body without thereby risking damage to the person. An anachronistic division of the human condition into what is medical (having to do with the body) and what is nonmedical (the remainder) has given medicine too narrow a notion of its calling. Because of this division, physicians may, in concentrating on the cure of bodily disease, do things that cause the patient as a person to suffer.

AN IMPENDING DESTRUCTION OF PERSON

Suffering is ultimately a personal matter. Patients sometimes report suffering when one does not expect it, or do not report suffering when one does expect it. Furthermore, a person can suffer

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