

Chapter 5

Reactions to Physical Illness
and Hospitalization

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EDITORS' INTRODUCTION

What is it like to be a successful businessman who is secure as a person, competent as an executive, is constantly being looked to for advice and leadership, and then suddenly to find oneself a patient in a coronary care unit? What is it like to feel helpless and totally dependent upon others?

The author delineates the cardinal features of illness. The loss of a sense of indestructibility, the loss of a feeling of connectedness to one's supportive interpersonal networks, the failure of logic when thinking about the disease, and the disappearance of a sense of control over one's life are all central to the experience of illness. The mix differs from patient to patient, but all four features can be found to one degree or another by the physician who observes, listens, and thinks. By means of clinical material and brief vignettes, Cassell brings to life that which the sensitive physician may discern. This chapter provides the physician with much to reflect upon, and a framework upon which to construct the understanding of illness. More than just illustrating a cognitive structure, however, the author illustrates the many ways in which physicians may use their understanding in the service and humanistic care of patients.

It has often been said that all physicians would be better physicians had they experienced hospitalization, a significant illness, or an opera-

tion—a full indoctrination into patienthood. Some physicians have their encounter with “the other end” of the physician-patient relationship. Even if it is as simple as a sigmoidoscopy, barium enema, examination of the genital area, or repeated blood surveys “for some reason,” something can be learned about patienthood. More frightening experiences, such as a lymph node biopsy, often strain the physician-patient’s need to be calm. Major surgical procedures, fever of unknown origin, a small infiltration picked up on a routine chest x-ray, “suspicious” cells in the Pap smear—the list of truly frightening possibilities is endless.

Most upsetting, however, is the experience of either severe or chronic illness. Here the physician may understand something of shattered omnipotence, disconnectedness, illogicality, and feelings of loss of control.

As Cassell brings it all together for the reader, it may become more “real.” Some physicians have the capacity to place themselves in the patient’s situation, others do not. A basic premise of this book is that this capacity can be developed or improved upon in most physicians.

What about the person who has abdominal surgery and has the need to show the surgical scar afterwards? How different it is for the attractive, slender woman who loves her bikinis and is undergoing abdominal hysterectomy! Readers may also reflect on how the patient with a permanent colostomy may feel. How important it is for the physician to take time to explain carefully to the patient not only about the care of the orifice, but also what can be expected in day-to-day functioning, including sexuality, exercise, and “noise.”

Some physicians are uncomfortable in talking about sex, suicide, dying, or any emotional problem. Some even have difficulty discussing excretory processes with patients. It is hoped that the basic attitude throughout this book will enable the physician to talk with patients appropriately regarding all body functions, physical or emotional. Cassell’s vivid way of bringing the reader into the patient’s room with him should be a great aid in their regard.

Recent research on the psychological results of cardiac surgery noted that while 90 percent of the patients who survived showed improvement in physical status, more than one-third developed psychological problems that strongly impaired their functioning. Even those with less serious difficulties appeared to be limited in one or more spheres; they did not return to work, resume normal activities, participate normally in their families, or return to normal sexual function. The surgery had improved the hearts, but apparently had not benefited the patients equally.

All physicians have had similar experiences. A man with a myocardial infarction may return to normal cardiac function. But after going home he may experience numerous symptoms, including sticking chest pains, easy fatigue, and poor exercise tolerance. His wife may complain that he is not the same as before the heart attack and not only because he has lost interest in sex. Such a patient may become more placid, but in any case he may lack his former drives and interests. His symptoms may be attributed to depression, and he may respond to antidepressant agents when they are used in proper dosage for a sufficient period.

Or perhaps he may settle down to a career of illness, and become preoccupied by exaggerated fears and crippling concern about the heart.

Why do these things happen sometimes to patients who have been seriously ill, and why did those patients not get the same benefit from surgery that their hearts did?

Every disease has features that are unique because of the physiology or anatomy of the organs involved. The heart can malfunction as a muscle pump, hydraulic system, or electrical system, and the symptoms of heart disease reflect these malfunctions. As that is true of the heart (or the liver, uterus, muscles, colon, and so on), it is also true of the whole person. When a person becomes ill, there may also occur a distortion of his or her relationship to the body, to other people, to work, and to the other aspects of being a person, a private individual, and a member of society. Such behavioral changes are often as much a part of illness as the disease itself. It follows that when sick patients get better, it is not only the diseased organ system, such as the lungs in pneumonia, that returns to normal, but also those activities that are involved in being a normally functioning person in the day-to-day world. We know much more about what happens when organ systems become diseased and then return to health than what happens when people get ill and return to health. Perhaps such a lack of knowledge was acceptable during an earlier period in medicine. Now, when we can do so much more for terribly complicated diseases, and when patients are less likely to die but may be sick for long periods of time before they recover, our lack of knowledge often hampers our patients in returning to their former selves. With a little more help, they could return to normal functioning. It is as simple as that.

Just as a heart or a liver can malfunction in only so many ways, the psychological changes that accompany illness are also limited, and can be described in an orderly and useful manner. The big difference is that our language for describing disease is more precise than the language for describing the "disorders of person" that accompany illness. For the former, we have objective measurements, while for people, our terms are subjective and thus seem "softer" and less real. To put it another way, sick people, no matter what the cause of their sickness, have certain characteristics that are different from those of people who are well. These characteristics are not chance or random events, but are definable, diagnosable, and relatively constant in occurrence. For this reason, the apparently illogical or difficult behavior of the sick is not at all illogical, but is the result of internal and external forces acting on the sick person. The physician must often manipulate these forces to return the patient to health in the same way drugs or other modalities are used to return a diseased part to health.

THE CHARACTERISTICS OF ILLNESS

Sick people suffer a disconnection from their usual world, a loss of their sense of indestructibility (omnipotence), a loss of the competence and completeness of their reasoning, and a loss of control over themselves and their world. These features, which will be explored in depth, are illness. When they are absent, no matter what the state of the body's integrity, illness is *not present*. Similarly,

