# Treating the Patient's Subjective State

*Eric J. Cassell*

What remarkable thing happened in the last generation so that adequate treatment of pain and even the relief of suffering are now legitimate goals of medicine that are frequently achieved? This is not the result of basic scientific discoveries—much about pain is as opaque to understanding now as earlier. Neither has it come about because of new drugs or technologies, because although there are some advances, older drugs and techniques would suffice. I believe that what has happened in these recent decades is that the patient's subjective state has increasingly become an authentic source of information and a valid basis for action. The trend to adequate relief of pain and suffering and public recognition of the validity of subjective states seems to have eventuated in a call by patients for active participation in their own deaths because their terminal illness is more unbearable than death itself. Dr. Foley does not believe that assisted suicide or euthanasia should be legalized, an opinion I share, but she strongly believes, as do I, that the profession of medicine has not given adequate attention to the subjective state of terminal illness. If doctors did pay attention, she thinks, they would treat these states better and suicide would not be necessary.

To suggest that the basis for these recent trends is the legitimation of patients' subjective states may seem strange, since doctors' actions are most often initiated by patients' symptoms, and symptoms are, by definition, subjective experiences. We have heard since our student days that most diagnoses are made on the basis of the patient's symptoms, but history taking is frequently abandoned in favor of objective tests and measurements. In the modern era doctors expect to find objective evidence that supports the patient's assertion of illness, or the claim will be denied. An example may make the point. A 67-year-old man complained of severe lower back pain, which was attributed to muscle spasm. Physical therapy had no effect and codeine gave him no relief. Because the pain had begun to dominate his life, magnetic resonance imaging (MRI) of his lumbar spine was done. It was normal. He was referred to a physiatrist, who looked at the MRI, did not examine the patient, and agreed that the pain came from muscle spasm. Further physical therapy was ineffective. Oxycodenone provided no relief. Because he had begun to lie in bed all day, other physicians were consulted who agreed that his problem was muscle spasm complicated by depression. Finally, 4 months after the onset of pain, another MRI was done, which included the lower thoracic spine and revealed malignant disease in the body of T12. Biopsy of that and another metastatic lesion discovered soon after showed metastatic cancer from the lung. This case illustrates the curious fact that the shadows on film—the MRIs—were considered more real than this man's complaints of pain and the changes in his behavior wrought by the pain. (The substance of this paragraph may seem at odds with my basic assertion in this commentary. In fact, it is. The two contemporary trends in medicine—increasing reliance on technology and the growing importance of patient subjectivity—are currently at loggerheads. Until they become integrated to form one medicine, there will be many paradoxes in medical practice.)

Despite this patient's example of an all too common occurrence, the importance of the patient's subjective state has grown throughout this century. In earlier decades, the importance of the individuality of the patient was seen somewhat differently. In a famous essay of 1927 called "The Care of the Patient," Francis Weld Peabody took pains to demonstrate to Harvard medical students that patients' symptoms might be real even in the absence of structural evidence of disease.[3] He explained that "The ultimate causes of these disturbances [the symptoms of the patients he discusses] are to be found, not in any gross structural changes of the organs involved, but rather in nervous influences emanating from the emotional or intellectual life, which, directly or indirectly, affect in one way or another organs that are under the voluntary or involuntary control." The influence on the body and illness of unconscious emotional material is now widely

From the Cornell University Medical College, New York, NY.

Reprint requests: Eric J. Cassell, 1550 York Avenue, New York, NY 10028.

accepted. This is what most people mean when they speak of the effect of the mind on the body. Here, the importance of the particularity of the patient is accepted, but it is not what we mean when we talk of the importance of subjective states. The formation of the unconscious material that causes physiologic change is beyond the patient's control. So, too, is a subjective state. We do not choose to feel pain, anger, despondency, happiness, grief, sadness, and so on. That unconscious conflicts cause symptoms is also beyond the patient's control. On the other hand, making subjective states known to others is often under conscious control. A much more important difference is that previously, while acknowledging the influence of the individual patient on the disease, physicians' interest was in the disease. Now, increasingly, our interest is in the subjective state itself. We want now to relieve the pain, suffering, hopelessness, loneliness, despondency, grief, and other subjective accompaniments to serious illness, even when we cannot influence the disease.

There is another, too often manifestly ignored, aspect of patient individuality that has a profound influence on the onset, diagnosis, treatment, course, and outcome of the disease, as well as on subjective states. This is the set of meanings that the patient brings to the experience of illness. All of us, sick or well, interpret what happens and form our responses to events by what they mean to us. There is no thing out there that humans know solely by their sensory input from the thing (including nociception); in all cases meaning is interposed. It is the meaning to the patient of the pain, the meaning of the disease, the meaning of the behavior of others, including doctors, that determines whether the patient will feel grinding pain, despondent, lonely, abandoned or instead an unpleasant constant ache, hopeful, brave, and determined.

Changing the unconscious determinants of behavior is difficult, time consuming, and beyond the training (and interest) of most physicians. Addressing the subjective state of the patient may mean prescribing adequate pain relief, or becoming aware of all the other emotional states and attempting to ameliorate them to change the overall state of being of the patient—often necessary, but frequently difficult. Meaning is another matter, however. Learning what meanings the patient has assigned to events and actively changing them can be a potent therapeutic force in itself.[2] There is nothing mysterious about working with the patient's meanings. The question, "What does that mean to you," will evoke the information. The physician then has the opportunity to offer alternative meanings. It does not even take much time. Considering these various aspects of the patient's subjectivity as though they were separate from one another, however, is a mistake. They are all part of this particular sick person. In fact, understanding them is the key to entrance into the sick person's experience of illness.[1]

What instrument will tell doctors about the subjective state of the patient? There is only one, and that is the subjectivity of doctors themselves. Thereby hangs the problem. Technology's promise is not only that it will reveal the secrets of the patient's disease, objectively and without depending on patient themselves, but also that it will free doctors from the need to be painfully involved with their patients. It is a false promise. There can be no successful care of the very sick or terminally ill without the doctor being closely involved with the patient and in the care of the illness. What is to protect doctors from the pain of such involvement? First, learning that the more total the involvement, the less the doctor will be hurt—the defense against the pain causes most of the pain. There is, however, a more important lesson. Medicine, in its embrace of science, has tried for almost two centuries to rid itself of the taint of doctors' subjectivity and the curse of anecdotal medicine. The result has been a wonderful science of medicine, effective and productive. The other result has been the separation of doctors from their patients. The time has come to understand that disciplined and systematic subjectivity in physicians is the tool that both teaches them about the subjectivity of patients and offers the opportunity to treat patients within this arena. Coming as close as humanely possible to patients, utilizing all the doctor's senses and emotions, and imposing as little abstraction as possible on the information received makes the doctor a diagnostic and therapeutic instrument suited to the care of the patients who are the subject of Foley's essay. Such physicians have the opportunity to care for these patients sufficiently to address their pain, their suffering, and the existential desperation that makes them want more to be dead than remain alive. With Dr. Foley, I believe the call for legalization of assisted suicide would lose its force if this standard of care was met in the United States. All experienced doctors know, however, that some suffering is so terrible that it cries out for extraordinary help. In this circumstance, some physicians, in the privacy of their relationship, will help some patients die. More important, however, is the fact that doctors who have trained this instrument within themselves will not only help many more dying patients than previously, but will extend their reach in the care of all patients.

## References

1. Cassell EJ: Uses of the subjective in medical practice. pp. 151–166. In Cassell EJ, Siegler M (eds): Changing values in medicine. University Publications of America, 1979