PERSPECTIVES

Why Should I Live in Pain?

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I am very tired. It is the last third of my intern year and the middle of my month of night float. During the past two days, when I was supposed to be sleeping, I was taking step 3 of the national medical board examinations. I am so weary that sleep is all I crave. All the usual pleasures of life are far away. During night float I spend my time prescribing midnight laxatives and sleeping pills, replacing IV lines and nasogastric tubes. They call me doctor, but they don't treat me like one. I don't feel like one. And lately I don't always act like one. I am not the person I was last July. I used to worry if I would be good enough for my patients, if they would consider me a doctor. Now, worn down physically and emotionally, I actually feel angry at the patients sometimes. They interfere constantly with my rare chances at sleeping or eating. All my lofty goals and ambitions from medical school have eroded down to a crude, instinctive desire to be left alone. Don't call me or need me; let me sleep.

The shrill of the beeper wakes me from shallow sleep. Actually, it only wakes me after my tired brain tries to incorporate the ringing beeper into my dream, and thus permit me to sleep those precious seconds longer. I sit up slowly and try to clear my head. My brain is still asleep, but the rest of me is wide awake, reacting to the surge of adrenaline caused by the piercing pager. While still slightly dazed and disoriented, rubbing sleep from my eyes, I feel my heart pound wildly. Apparently the fight-or-flight response is not designed for weary interns. As always when answering these early morning pages, I hold my breath. I am sure that if I don't show the proper respect for my electronic taskmaster, the voice at the other end of the phone will utter an arrhythmogenic phrase such as "code blue" or "chest pain."

This time it's Mrs. Murphy in room 7618. The nurse tells me that she is in pain again. I look at my signout sheets: 84-year-old, white female with metastatic lung cancer. Everywhere. DNR. This is not going to be an exciting diagnostic dilemma. Still, it will require that I leave the sanctuary of my call room and brave the floors. Each call carries with it the underlying tension of the night. I

am a doctor without a safety net. No residents are here to question my every move. If I say "give the heparin," or "hold the diuretic," it will happen. Of course, most of the time there is nothing medical about it all, just reflexive answers to rote problems. Still, as I walk down the hallway alone for a moment with my thoughts, I wonder why they think I'm a doctor. Rarely do I know any more about a question or problem than anyone else. I know that the letters after my name signify something worthy of the title. But if it's not a fund of knowledge that I can offer, then what am I here for? "More learning," I can almost hear a thousand former teachers say. It is strange to be called something that I don't feel worthy of. Everyone must be able to see this. I feel like a fraud just waiting to be found out.

I review Mrs. Murphy's chart. She has many bony metastases. As a weary and detached intern might quip, she has mets to the patient in the next bed. She has been on standing doses of subcutaneous morphine, with occasional rescue doses. Before I even make it down the hallway to her room, I say to no one in particular, "What is the point of being a doctor if all I do is temporize? We never really fix anything." If anyone heard, they didn't answer. I ask the nurse, "Why is she here? What can we do for her? Doesn't she know that it's three in the morning, she has a terminal illness, and that she has "prn" morphine ordered already? What does she want from me?"

So not exactly feeling like the angel of mercy, I enter her room and look at her. I see that she is actually just a collection of features. Her terrified eyes protrude from a living corpse of cancer-ridden bones and baggy skin. I imagine that in long ago, happier times, her skin probably fit her perfectly. Her white hair is matted and greasy. Apparently she has lost the physical ability or the desire to wash and brush it. Even so, she still exudes an air of dignity. She is not writhing in agony, but simply suffering quietly, almost hopelessly. She strikes me as a proud woman, who took care of others her whole life until recently. Now she is surrounded by half-full urinals, dirty sheets, and IV lines. Everything around her is a testament to her illness. Does she even know or care what is flowing from the hanging bags into her veins? I wonder whether it is the physical pain or the dependence and infirmity that distresses her more?

She is very angry with me although I have never met her before. Her crystal blue eyes fix on my tired ones and she whispers accusingly and with great effort through her pain, "I've signed all the papers already. They said they

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would make the pain stop, but they didn't." My instinct is to react to this room charged with emotion with clinical detachment. "Where does it hurt? How much does it hurt? What makes it worse or better?" These technically correct but ridiculously inappropriate questions, learned so carefully in physical diagnosis class, were ignored. "They lied to me. They told me to sign the papers. I did, and I'm still in pain. Why should I live in pain?"

I do not have a good answer for her. Here, in the middle of the night, two very cynical hearts meet. Perhaps hers is more so. I realize that explaining the technicalities of a do-not-resuscitate order is useless and beside the point. She is not interested in the legalities of it all, and actually, neither am I. It doesn't matter whether she is DNR or comfort care or even DNL (do not look). Something about her moves me. Seeing her suffer stirs up strong feelings in me. It is basic and instinctual. I see her in pain and I want to stop it. Old buried emotions begin to flood my mind. I begin to recall why I went to medical school. I simply wanted to learn how to help people. In the end it is no more complicated than that. Of course, helping people in the abstract is easy. The problems are fixable. In real life they almost never are. All year long it seems that I have been swimming against an inexorable tide of pain and suffering. Each wave brings more and more and I can't keep up. I will never be able to cure most of my patients, including Mrs. Murphy. She and I both know that. Yet she asks for my help. Can I still be a doctor to someone who is so ill and beyond the healing powers of all the high-tech wizardry at my disposal?

She seems to think so. She has been asking for one all along, to help her feel better, or at least pay attention to her. She isn't asking me to cure. She is asking me to care. During this frozen moment, while I stare into her eyes, it occurs to me that treating her pain is every bit as "medical" as was staging her cancer by laparotomy. I certainly cannot perform miracles and save her with my magic touch. However, I can dispense with all of her CT scans and pathology reports and do exactly that which originally drove me to become a physician, help her feel better. It may not be Nobel Prize material, but it is medicine nonetheless.

I stammer something about getting some medicine and leave the room. I no longer feel hassled or harried. I

realize that I do possess the skills and knowledge she needs right now. I can help her. On my way back to the nursing station I hear her begin to cry; she must think I'm leaving her alone again. My heart is in my throat from both her cries and my own surge of emotions. At last I feel full of real purpose, and can hardly wait to get the morphine and get back to her room.

I draw the morphine into a syringe. Looking deep into her pain-filled eyes, I promise, "I will help you. I will give you enough morphine to take away your pain." She grunts and looks away from my gaze. She has heard this too many times before. She doesn't know that I mean it. The first few doses don't touch her. By the third or fourth dose, I begin to get a little nervous. Am I now getting carried away, overzealous? I remember what I learned in medical school, specifically, that if a patient is still in pain, a little more morphine is safe. However, it is 3:30 AM, we are alone, and none of my medical school teachers are here right now. For a moment she looks at me wondering if I am going to give up. I remain silent. She has heard more than enough talk. When I draw up another dose, and move toward her to inject it, a slight, but perceptible look of appreciation crosses her face. This serves to steady my hand and I continue.

Several doses and a few skipped heartbeats later, while I hold her bony hand, she really looks at me for the first time. She lets me know that she feels much better, not in words, but by the easing of tension from every muscle in her body and by the look of peace on her face. She manages to whisper a slightly slurred, "Thank you." I have now brought her to the precipice of death, the small zone where she is both pain-free and alive. I feel almost as much relief as she does.

I am no longer tired, the call room can wait. I hold her hand and watch her. Perhaps I am just making sure she continues to breathe. I know that I want to be there to witness her peace and to share in it. I believe that I have rediscovered my ability to see who she really is. She has been a wife, a mother, and a grandmother. She has been a best friend and the love of someone's life. Only much later on did she become a patient. I hope that I will never again see her as an obstacle between me and my pillow. I sit at the bedside matching my breaths to hers, and feel more like a doctor than I have in a long time.