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EDITORIAL

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Recognizing the patient as "other"

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This issue of our journal features an insightful article by Drs. Vegni, Mauri, and Moja exploring physicians' reactions to the pain and suffering of their patients in the attempt to identify those cognitive and emotional dimensions of "doctors' internal representations of the clinical relationship with the suffering patient", which in turn can "influence the communication with the patient in pain" [1]. Following the increasingly valued methodologies of qualitative analysis [2, 3] and of narrative in medicine [4], the article makes use of doctors' stories as a powerful tool to "allow the researcher to approach the participant's experiential world in a more comprehensive way" [1]. One hundred fifty-eight physicians of different specialties who were attending a series of courses on the communicative-relational aspects of the clinical meeting with the patient in pain were asked to write about a difficult encounter with such a patient. Eighty-four of these narratives referred to cancer patients. The narratives were then analyzed according to a clinical-interpretive method, the objective of which was "to reconstruct the internal representation of the medical profession (not of any individual doctor) with regards to the relationship with the patient in pain" [1]. The authors identified three main perspectives through which different stories could be read, and they named them "the biological, the professional, and the personal perspective." The Authors remarked that within each individual doctor's narrative, there was almost invariably a certain degree of shifting among these three perspectives as "the encounter with the patient in pain seems to be experienced as a place where the doctor feels unable to cope" [1]. Finally, the Authors concluded that while the biological perspective is reductive and culturally unacceptable, the personal one is overinvolved and emotionally untenable. On the contrary, the professional perspective of the doctor "meeting the other as person" who owns his or her own pain seems to open an acceptable, albeit "new, unknown and uncertain professional space beyond the disease" [1]. (In the English language, there is a distinction between "disease" as the biomedical and "illness" as the lived counterpart of the same phenomenon. This distinction goes beyond semantics, and confusion between the two terms can be at the origin of profound misunderstandings and lack of effective communication between patients and their physicians. In this editorial, I will therefore only refer to illness). In the "professional perspective," the doctor's meeting is not with the body in pain but rather with the suffering person [1].

As the Authors state, in this apparently "not extreme perspective," the doctor witnesses and acknowledges the complexity of the patient's experience of pain as well as of the meaning that each person attributes to that suffering in the context of personal illness and life. In other words, the doctor recognizes the patient as "other." What, exactly, could this mean?

According to Emanuel Levinas, the Other who suffers takes precedence over any abstract suffering. One's relationship to the Other is the foundation of human knowing. For Levinas, most Western philosophy "has subverted the ethical relation to the Other by replacing persons within the ongoing system of ontology, hence denying persons their otherness, their alterity, and their unencompassable transcendence." [5, 6, 7]. In a recent paper, Michelle Clifton-Soderstrom, following Levinas, claimed that "the moral obligation of the physician is imposed by the patient as Other, an obligation that is prior to the interpretive framework of medical knowledge" [7].

While in my opinion the patient–doctor relationship exists together with (rather than prior to) the knowing relationship to the Other, it is a fact that in clinical medicine we cannot abstract the illness from the ill person. Illnesses occur in real, embodied others who have emotions, feelings, and rational thoughts and live them in a specific social, cultural, and familial context. The ill person is Other from the physician and yet needs the Other (the physician) in a very special way to "decode the message hidden in the illness" [8]. This is especially relevant when pain and suffering are involved in the patient–doctor encounter. Pain often acts as a new mediator between body and consciousness. The patient's individual experience of suffering is primarily a bodily experience where "primarily" indicates a chronologic as well as a logic primacy. Of the body and through the body we have an experience that is not intellectual. The body is something that we live rather than an object of our thoughts [9]. The professional perspective described by the authors recognizes the Other as the living subject of the pain [1].

There is also a different way to interpret the meaning of "other". Virginia Held addresses a domain frequently neglected in moral theory: the realm of caring for "particular others" [10]. The patient–doctor relationship can be seen as an instantiation of Held's relations among particular others. Clearly, the ties between physician and patient are not created solely through a process of deduction from an abstract concept of universal ties among general others. On the contrary, these ties are established in a concrete relationship among embodied human beings. The connection between the physician and patient is based on a form of intimate contact, which crosses the usual borders of physical, personal, and emotional privacy.

According to Held, relations among particular others share three main characteristics: (1) In most cases the self (in our case, both of the patient and of the physician) relating to the particular other is already entwined in other important relations; (2) the relation is often "more real, salient and important than the interest of any individual self in isolation"; (3) the particular others are not 'all others' or a universal 'everyone,' but rather "particular flesh and blood others for whom we have actual feelings" [10]. Each patient is an embodied fellow human being with thoughts, emotions, and feelings. The physician is interested in a particular patient and cares for that patient in a particular rather than a universal way. While clinical medicine also requires the doctor's ability to use inductive and deductive methodologies, the patient–doctor relationship develops in terms that are neither abstract nor universal. Rather, it develops in "particular terms." Each physician has a specific relationship with each individual patient, no matter how many patients he or she may see in one single day or in one year. Furthermore, each patient–doctor relationship is unique, if only for a few minutes. In the professional perspective described by the Authors, the physician recognizes the patient as a particular other whose pain and suffering cannot be cared for by way of abstraction and generalization [1].

The patient–doctor relationship ideally is a therapeutic alliance where the two partners are bound by justice and trust in a goal-oriented, mutual, yet asymmetric relationship of help. The true essence of the partnership between patient and doctor lies in this asymmetry of help where the patient's suffering is always qualitatively, and not only quantitatively, different from the one that the physician may share with the patient under the effect of compassion and empathy [11, 12]. Yet, "the uncertainty, fear of loss, and helplessness experienced by patients are typically mirrored in the responses of their physicians" [11] as an empathic reaction to the patient's suffering as well as a direct reaction to the great responsibility involved in the physician's role and to the awareness and fear of the inevitability of illness for all of us [13, 14].

In their article, the Authors refer to the doctor's point of view as "that of 'he/she who heals' or is 'responsible' for healing pain" [1]. The responsibilities of the physician are enormous, and they can only be fulfilled when the patient–doctor relationship is seen as a professional relation of help with clear boundaries [15]. Boundaries are necessary to the therapeutic *telos* of the relationship, as they protect both partners from its inherent many risks, including excessive intimacy [16], and facilitate the overcoming of the many obstacles that both patients and doctors encounter in communicating with each other. These boundaries are first and foremost epistemic but also interpersonal emotional ones. Medical practice, in fact, also involves doctors' feelings and intuitions that come with empathy and closeness to another human being [17]. At times, it becomes necessary to construct boundaries against being too engulfed by these intimacies or against the temptation to escape painful moments through excessive distance. The setting of appropriate boundaries in the patient–doctor relationship also helps confine the patient's illness within certain logic and temporal limits in order to counteract to some extent the "totalizing" effect of illness on the patient [18, 19].

By recognizing each patient as "other," the physician is most effective and feels most at peace in the patient–doctor relationship, which should be based on respect and acknowledgment of the particular Otherness of the patient, as well as on the closeness and boundaries, that can make the relationship profoundly rewarding for both partners. The article by Drs. Vegni, Mauri, and Moja illustrates this point very effectively when describing the professional perspective as "the only place in which doctors could be able to stop" in their journey "without peace" when meeting a patient in pain [1].

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