Compassion and Medicine: Facing the Challenges of Physiatric Practice

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I contracted chicken pox when I was 27 years old in a foreign country while doing my fellowship in rehabilitation medicine. I was brought to the University Hospital, then ushered to a corner in the Dermatology Ward where the resident physician was going to do a physical examination, or so I thought. Not being fluent in English, the resident physician motioned for me to remove my shirt, which I did, showing the vesicular and pustular eruptions on my face and chest. Then all of a sudden a swarm of medical students surrounded me. "Oh my, so this is how it feels like!" I said to myself as I remembered the countless times, as medical students, my groupmates and I surrounded our patient for the week at the Philippine General Hospital (PGH) wards. I felt so ashamed and wanted to cover myself but the resident physician again motioned for me to stay as I was. He was pointing to my lesions and explaining something to the medical students which I could not understand. I saw at least 24 eyes staring at me at the same time and I thought I was going to melt. I prayed that I would not be admitted to that hospital and luckily there was no vacancy in the ward at that time and I had to be transferred to another hospital. At the other hospital, the consultant and resident physician took time to explain how I was going to be managed and for how long I was expected to stay in that hospital. The nurses brought a dictionary for me to understand what they wanted to ask. I made friends with the other patients in our bay and learned more about the language, culture and customs in 10 days than in my six months in the language class. I also resolved to be more compassionate, humble and respectful to my future patients.

Very often, medical students are exposed to patients who function as specimens under a magnifying glass, and they seldom have the opportunity to spend time listening to patients reflect on the meaning of their illness and the quality of care they have received.[1] The focus has always been to finish the task for the day at the soonest possible time so that there would be time left to study for the non-stop voluminous academic workload. It then becomes difficult to see the patient behind the illness which could prove disastrous to the patient, the doctor and the medical profession in the long run. But then again, didn't we enter the medical profession to help our fellow men, ease our patients' suffering and make the patient whole again?

Consider the following:[2]

- The most frequent comments from patients concern the attitude of physicians.
- The most common reasons for lawsuits have some link with the physician's attitude.
- In the most technically advanced medical environments we cure 40 percent of diseases.
- Pain, with its huge emotional component, is the most common complaint.
- What has made the value of our profession as physicians is the ability to deal with very personal issues.

What can we infer from the above? That while making the correct diagnosis and prescribing appropriate medications are important, healing also involves compassion and caring. Compassion comes from the Latin "passio" meaning *to suffer* and "con" meaning *with*, thus compassion denotes "*feeling sorrow for the suffering of others accompanied by an urge to help.*"[3] Caring is defined as *"being responsible for, looking after, providing for."*[4] Treating patients with compassion and caring could relieve much of their psychological and emotional burden and be motivating factors to active participation in the rehabilitation program and, consequently, their recovery.

In the rehabilitation medicine practice, patients usually consult because of impairment of function or disability, which may be due to painful muscles and joints, hemi- or paraplegia, fracture or loss of a limb or body part. The impairment is usually accompanied by a loss of positive body image, depression, and a sense of helplessness. Being unable to perform the simplest activities of daily life can be overwhelming. In the process of optimizing a patient's functional abilities, compassion then becomes a very important ingredient in rehabilitation management. Compassion includes the elements of attentive listening,

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attention to detail, explanatory communication, patience, concern, and consideration.[3] The interdisciplinary team approach to rehabilitation stresses the humanistic nature of the specialty, understanding the patient as a person, respecting the person as an individual and showing compassion for the patient's impairment and disability. The team is composed of a physician, nurse, physical therapist, occupational therapist, speech therapist, psychologist, social worker, dietitian and even a priest or pastor. Thus, the process of rehabilitation becomes a healing of the body, mind and spirit.

I am reminded of mentors and colleagues whose compassion and vision made the rehabilitation medicine specialty what it is today. Dr. Guillermo R. Damian was the first chairman of the Department of Rehabilitation Medicine (DRM) at PGH and he was also the first Dean of the University of the Philippines (UP) School of Allied Medical Professions (SAMP), the first allied health school in the Philippines. The school eventually became what is now the College of Allied Medical Professions (CAMP) and has graduated thousands of collaborative members of the rehabilitation team assuring interdisciplinary care of persons with disabilities (PWD's). In the same manner, the PGH has produced hundreds of rehabilitation medicine specialists, also called physiatrists, who now occupy vital positions in the fields of health and medicine both locally and internationally.

Dr. Antonio O. Periquet started Community Based Rehabilitation (CBR), and is still very much into it. Since the Philippines is composed of more than a thousand islands with various mountain ranges, and tertiary healthcare services are concentrated in the highly urbanized communities while 70% of the Filipino population live in the rural areas, accessibility to rehabilitation services has been a huge problem. Dr. Periquet conceived of a way to bring rehabilitation services to various Filipino communities by training local health workers in the rural communities to care for the disabled by means of a transdisciplinary approach and using indigenous materials for functional training, e.g., use of the coconut shell and bamboo for splinting.

Meanwhile, Dr. Quintin F. Oropilla emphasized proper attitudes towards mentors, peers, patients and work. All his students could not forget his favorite one liner: "You better shape up or we ship you out!"

Today, the DRM has a highly organized Stroke Support Group called PARAISSO, which meets in the Department at least once a month to discuss various issues related to stroke and its complications. Various members of the rehabilitation team and invited guests facilitate the group discussions to better understand the medical, social and psychological concerns arising from stroke. The group was founded by DRM's "mother hen," Dr. Betty Dy. We also have a dynamic rehabilitation program for amputees, headed by Dr. Josephine R. Bundoc, providing very affordable prostheses from reused and recycled imported prosthetic components. Our prosthetists now share their expertise and train other technicians from different parts of the country.

A few days ago, a member of the press asked me, "What does a rehabilitation doctor do?" I answered: "In the process of restoring the patient back to a normal or near-normal lifestyle, we make the person whole again."

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