SUFFERING OF PATIENTS IN THE DEPARTMENT OF INTERNAL MEDICINE AND IN HOSPICE

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Abstract
Suffering that accompanies a disease can be mitigated, but not completely removed. Health professionals’ attitudes toward suffering should be full of efforts to understand human suffering and to mitigate the suffering on both professional and human levels. Medical personnel should be able to control the depressed feelings of a suffering patient; on the other hand, they should avoid another extreme, namely emotional indifference. Thus the main object and purpose is to reduce, and if it is possible to completely eliminate suffering associated with disease. If, despite of all efforts, we cannot eliminate suffering, the main role of healthcare professionals is therefore to preserve the dignity of a sufferer; his interpersonal relationships; approach him with humility; respect and maintain his quality of life at the required level.

INTRODUCTION
The issue of suffering is very broad and extensive. Most authors are primarily concerned in its physical form, i.e. pain. But the issue of psychological and social suffering has been less often described. In our work, we point out that at all aspects (bio-psycho-social and spiritual) of a patient can be influenced by suffering.

THE CONCEPT OF SUFFERING
"Pain is considered the most common source of suffering, and to the extent that two terms - pain and suffering - are usually associated, they are different forms of hardship." (Munzarová, 2005, page 74). The term ‘pain’ includes many other forms of human sufferings. Our native language does not distinguish whether it is physical or psychological pain, but the English language recognizes the concepts of ‘pain and suffering, which are used as synonyms. Pain leads to suffering, and suffering leads to a painful behavior (Janáčková, 2007, Raudenská, Javůrková, 2011).

"Since the beginning, humanity has been pursued by a wide range of diseases and people have tried to fight against suffering, pain and death" (Kopáčková, Cetlová, Stančiak, 2012, p 171).

Disease can be defined as a disorder of health. Like the concept of health, disease again can be based on a holistic concept - the concept of wholeness of a person in all its physical, psychological, social and spiritual areas (Zacharová, 2007). As stated by Křivohlavý (2002) disease is a state when there is something wrong, something that is beyond normal boundaries. Other authors characterize disease as a state of discomfort when a person does not feel well, and therefore is unable to fulfill her/his duties and assume her/his social role (Bártllová, 2005). The word disease is thus understood under two different concepts ‘disease’ and ‘medical discomfort’ (illness). The term ‘disease’ means deviation from certain specified standards, manifesting specific symptoms that can be
diagnosed. Disease is a biological phenomenon. The term ‘medical discomfort’, which can be seen by human emotional expressions, tells us that a given person is not well. Health discomfort is a psycho-social phenomenon (Zacharová, 2007).

**SOMATIC-PSYCHICS AND PSYCHOSOMATIC PAIN**

Efforts to reduce pain had been of great importance in ancient times and this has persisted into the present (Trachtová, 2010). Among fundamental human rights belongs the right not to suffer pain (Janáčková, 2007).

Different physical or mental factors are involved in every pain state (not in the same manner and not to same extent). Body condition (health) affects the human psyche and the psyche affects the somatic human condition. Like any disease and pain, at the moment it becomes disease there are somatic and psychological components. Therefore, in any manifestation of disease, medical staff must take notice of these two components. In somatic disease it is necessary to know a patient’s mental state - mental strength, his efforts to heal and cooperation with the medical staff. We are talking about diseases as somatic-psychical, manifest deficiencies in the body, which in turn induce response in the human psyche. But disease affects more than the physical level. In psychosomatic illnesses it is also necessary to discover not just the physical condition because the cause is probably in the psyche, (Rokyta, 2009, Zacharová, 2007).

Adaptation to pain is small, but some chronically ill and people with cancer eventually learn the limits of pain, can control it and grow familiar with their pain. Pain takes a great toll on people - it changes their mind (frustration, depression, hopelessness, anxiety), mood and behavior (aggression, isolation) and their way of life. Prolonged exposure to unpleasant stimuli of chronic pain causes heavy sufferings; exhaust patients; make them feel exhausted and depressed. People suffering from chronic pain respond inadequately to common factors. This is pain that falls into somatic-psychical diseases (Trachtová 2010, Zacharová, 2007).

Psychological reaction to pain is suffering. Pain intensity consists of sensory and affective components. From these come the need not only of conservative treatment with drugs, but also psychological therapy which is often more effective with chronic pain than analgesics or opioids. Suffering does not always arise from pain due to physical disability, but may also result from long-lasting negative psychological processes (stress, fear, anxiety), which are reflected by a painful experience. This suffering descends into psychosomatic diseases (Trachtová, 2010).

Response to pain is different for each person and it is even different for the same person at different times depending on the inner experiencing of pain. People experience pain harder and more sensitively in a case of fatigue and exhaustion of the body, or if it is accompanied by fear (from examination or from intervention) and previous negative experience. Conversely, patients with severe depression experience pain less intensely and are less sensitive to it. Experiencing pain is influenced by learning; possible rewards; previous experience with pain; understanding the meaning of pain; personality traits of a person; and by educational and cultural influences from society (Various authors, 2006, Šamánková, 2011, Zacharová, 2007).

**REDUCING OF PAIN CAUSED BY DIFFERENT KINDS OF SUFFERING**

The main objective is to reduce the suffering that comes with pain. A patient has the right not to suffer pain, and from it comes the right to timely and professional treatment of pain (Janáčková, 2007). If a patient is given appropriate treatment, which helps to relieve him/her, then a patient does not ask for pain medicaments; the pain becomes bearable; and people tolerate it more. Not very strong pain leads to suffering if the sufferers fear that it is the cause of serious disease. On the contrary, suffering of tremendous pain may not be perceived as suffering if there is a hope that it will end soon and if he/she knows its cause (Munzarová, 2005). Today, most people tolerate pain much less than previous generations. It is a fact that life has become more comfortable than it was before. Even at low intensity pain doctors often prescribe analgesics and opioids, because for them it is the simplest technique to reduce or eliminate pain. Opioids should be used only when needed to reduce large, unbearable pain. They have many side effects and incorrect dosage (right drug, dose, route and fre-
quency of administration) may become addictive but they do not destroy the psyche of a patient. On the contrary, a patient will not be completely exhausted by terrible pain and will be able to communicate with loved ones. Finding, uncovering and sharing the difficulties of a different kind (bereavement, lack of hope, missed objectives, feelings of guilt, loneliness, fear, remorse), which is not related to a disease itself, leads to tolerating more significant pain. According to this rule, especially in a hospice, staff provides full healthcare. Through this kind of suffering most aware experts are focusing on mental and spiritual diseases. It is important to bear in mind that access to healthcare treatment of pain means a personal approach to suffering of patients, because it entails everything from his/her past and sustains their bio-psycho-social and spiritual needs. Doctors should learn and try to implement psychological means necessary to relieve pain or other means to improve the psyche such as walking in nature; talking; relaxing; sympathy; understanding and empathy; education and the provision of sufficient information; relaxation exercises; etc. (Bírešová, 2011, Munzarová, 2005, Zacharová, 2007).

Mental Suffering

Psychological needs are based on personal perception and experience of the world and on the need to develop personality (Šamánková, 2011). Among these needs primarily belong the need to respect human dignity, which is one of the most important aspects in the care of the sick. Human dignity is understood as respect for human existence regardless of age, social status and health. Dignity is a human to human tribute. It is also related to the ability of a person to create a meaningful picture of his/her life and him/herself. The need for dignity is not only important in terms of care itself, but also for good relations between patients and health professionals. Respect for human dignity concerns all medical staff including cleaning workers in a hospital, family members and friends of patients, especially in cases of severely ill and dying patients. All of the above are responsible for ensuring that a patient does not suffer from worry, fear and anxiety, therefore he will not have psychological suffering caused by ignorance, humiliation, by saying untruths etc. Doctors must respect the dignity of a patient when communicating serious diagnosis. In practice, importance of respect for a hospitalized patient in healthcare becomes somewhat reduced and suppressed. Healthcare professionals often fail to respect human dignity; don't accurately write all interventions which they performed on a patient; a patient is almost treated as a ‘things’; emphasis is on doing everything right according nursing practice; but somewhere along this is diminished interest in a person as such. An ordinary human approach toward a hospitalized patient is reduced and he/she then experiences a loss of personal identity (depersonalization); a patient becomes the subject of ‘business’ for a medical facility; and human - a living being - in nursing care is overlooked. A patient may lose dignity simply by addressing (‘Grandma’, ‘Grandpa, without addressing a name); how answering of questions (austerity, arrogance, irreverence, aloofness, abruptness, simplification, diminutives). Self-dignity of a senior, the sick and elderly people is usually impaired by shame (embarrassment) during intimate performances such as personal intimate care, examinations from head to toe, dressing, defecation or exercises. This disruption of intimacy is changing the identity of a person - the loss of self-esteem; undervalued feelings of inferiority; powerlessness; feeling of her/himself as a burden for the institution. The loss of dignity may happen with the decreasing of value of an elderly patient, who at least in experience, wisdom, life and destiny that was reached in active life in her/his former social position in society.

A patient is terrified and worried about the symptoms and the disease itself, which he/she later experienced upon entering a hospital or other medical facility, at which time mental tension escalates. Everybody needs a sense of psychological and physical safety and security in life. When a person is in a medical facility he/she does not know, he/she encounters unfamiliar people and things, so feels especially threatened and frightened. It is for him/her a new environment where his/her need for privacy is disrupted, which is changing his/her social role from a healthy to a patient; from an independent being to subordinate of doctors and medical staff. For humans it is very difficult to obey and accept the fact that an active individual becomes a patient - someone who is dependent on the help of others because he/she cannot help him/herself. Here the ability of medical personnel, such as humility, respect, gentleness and sensitivity in
dealing with patients, or when communicating with them plays a critical role. The most important principle of healthcare should be truthfulness. According to Svatošová it is also important to tell a patient only as much as he wants to hear; when he or she wants to hear it; and is able to perceive us and listen to us. It is essential to gain the confidence of a patient in order to create a positive relationship with a patient for his/her support and for hope (Svatošová, 2012, Venglářová, 2007).

A disease goes hand in hand with stress. This intensifies a simultaneous action of fear and anxiety. People controlled by stress, respond too sensitively and are tense; impatient; irritable; have negative thinking; focus less; have extreme tiredness; apathy; depression; or vice versa aggression and malice; and all these are reflected in their relationships with others.

Once medical staff understands the stress behavior of a patient, it helps a patient to prepare for an upcoming stressful situation; try to minimize what causes stress for the patient; participates in his suffering; helps him/her to maintain a positive mental balance and thoughts; and finally, helps him/her maintain good relations with those closest (Opavský, 2011).

**SOCIAL SUFFERING**

One of the most stressing factors in human life is a fear of being alone. This means that a human is naturally given to be in community with others; be in contact with them; talk with them; share their opinions, knowledge and ideas. Man needs society; can never exist as an individual; and cannot be alone for a long time (Křivohlavý, Pečenková, 2004). These assertions imply the need for interpersonal relationships. This need is disrupted by illness, hospitalization itself and becomes social suffering to a human. Admitted to a medical facility, a person is torn from a network of social relations he/she had with others; limits their contact with loved ones (family members, friends); and interferes with relationships between them. A patient, therefore, who has lost some of his/her social role will suffer from feelings of social isolation. And, if is not attended by family, a patient is forced to actively seek new ties - he must find someone to be 'linked to who will be a friend, mentor, whom he could trust; to whom he could rely on; who would have listened; tried to understand him; and protect him (Zacharová, 2007).

The only people with whom a hospitalized patient is in contact with are other patients, doctors, nurses and other medical staff; most often, however, it is nurse because she is, on a human level, a person closest to a patient. In some cases, particularly in the elderly, there may appear a generation gap from nurses or a negative attitude towards old age; the interest and care of young patients is preferable to focusing on elderly patients. Thanks to resulting social isolation, especially in older people, it is very difficult to maintain their self-esteem (increasing sense of loneliness; creating of a feeling of separation); will seek company; will want to talk; to draw attention to him/herself, and therefore a nurse should spend as much time as possible with patients and not with administration or working at a computer. Here are qualities nurses should have and apply when dealing with a patient: be patient; attentive; friendly; optimistic; communicative; be able to listen and show interest; get along well with others; be resolute; willing; honest; fearless; etc. In disease a human loses his ability to work; is taken out of active work which he held in his job. When hospitalized, a patient directs his resources at combating a disease. A patient does not want to be a nuisance; passive; but would like to be actively involved; apply; collaborate and participate in his/her treatment. For example, an ordinary morning exercise; performing manual work help patients to gain back confidence; instill positive results to help overcome negative thoughts, anxiety, pain. The need for a positive review - it is a social need which is important for a patient featuring the art of praise, encouragement, appreciation for the effort.

Another social need is for respect of social identity. This is need for a person to be recognized, respected and integrated into a team that treated him fairly, with respect, tolerate his mood swings and respect his/her scale of values. Among social needs also belong needs for kindness and love. They are externally satisfied by a nurse being kind, empathetic, attentive, sensitive and understanding of a patient (Bártlová, 2005, Křivohlavý, 2010 Venglářová, 2007).

Social needs are also connected with cultural needs. Cultural environment and aesthetics allow a sick person to distract attention from himself, from his
illness, pain and suffering. Long-term disease affects all social and cultural activities. It is very important to know what a patient used to do (whether he watched information of what was happening in our country or in the world; that he regularly went to theater, cinema or concerts, exhibitions, or preferred watching television) before coming to the hospital or other facility. Depending on his/her lifestyle, on hospital equipment and on medical condition of a patient, we can provide small degrees of cultural activities to take place within a hospital; allowing TV watching; listening to radio; to inform about is happening outside a hospital from a website; provide literature. Some facilities even have a separate parlor dedicated for meetings with families or other capable patients themselves; where coffee is provided at a certain hour; games played; manual labor performed; and where there even should be piano. Making contact with other patients is a source of support for a patient; they can share their own experience which leads to mutual understanding of their situations (Křivohlavý, 2010 Šamánková, 2011).

SPIRITUAL SUFFERING

In addition to biological, psychological and social needs in humans we must take into account their spiritual needs, which also have impact on the experience of suffering in humans (Janáčková, 2007, p 17). This includes spiritual focus on human aspects such as religious, philosophical and psychological feelings. Spirituality deals with problems; with the overall mood of a person’s thoughts; with questions that go beyond the human; questions about the meaning of life, of its origin. It positively affects the human capacity to cope with difficulties that are associated with the disease (Raudenská, Javůrková, 2011, Šamánková, 2011).

Spiritual needs are not widely discussed, but from a holistic point of view we should not underestimate them (Svatošová, 2012). A deeper understanding and integration of spiritual care in treatment increases the effectiveness of treatments selected by physician and health-care team. But do we know that a patient has spiritual needs? To find out what patients have spiritual needs, we must first find out what environment and life situations patients come from to the hospital. A patient may trust himself to have such and such suffering. We can learn a lot of information from the patient's family or the objects that a patient has with him – a cross, Bible or other religious book (Raudenská, Javůrková, 2011, Svatošová, 2012).

Meeting spiritual needs is important for peace of mind. It can bring great relief and strength to a patient. Surprisingly, ‘non-believers’ have spiritual needs rather than ”religious” people. This is because in a state of dying ‘infidels’ think about their lives; whether bountiful or unsuccessful; think about their failures that are not reconciled with the world, with loved ones, and thereby with God. A magnificent step forward is to die with a feeling that everyone close forgives us and that we forgive all those who have hurt us (Svatošová, 2012). On the contrary, ‘religious’ people have a perception of God, and therefore, take such a stressful or difficult situation, as an opportunity, a challenge that opens them and significantly expands horizons and makes ‘believers’ ask key questions. ‘Something is wrong and it happened therefore, that something has to be changed, while still changeable’ (Svatošová, 2012).

THE METHODOLOGY AND RESULTS OF RESEARCH

In our work, we focused on finding symptoms in suffering patients from the perspective of nurses. The research was conducted at two internal compartments in two hospitals and in two hospices. 120 questionnaires were sent out, of which 101 were returned.
Suffering of Patients in the Department of Internal Medicine and in Hospice

THE STRONGEST FORM OF SUFFERING FOR A PATIENT

Figure 1. The strongest form of suffering for a patient

Of 44 respondents working in hospice facilities, 25 (57%) stated that the strongest suffering is from a patient’s physical pain; in second place was emotional pain which was reported by 9 (21%); 7 (16%) psychosocial suffering perceived as the least suffering for a patient; and 3 (7%) respondents spiritual pain. Of 57 respondents working in Internal Wards of hospitals, 31 (54%) say the strongest suffering for patients is physical pain; followed by 15 (26%) suffering emotional; 11 (19%) psychosocial pain. No respondent answered that the strongest suffering for a patient in an Internal Department was spiritual pain.

The above Figure 1 shows that in both hospices (57%) and in Department of Internal Medicine more than half of the respondents (54%) identified physical pain as the greatest suffering which hospitalized patients can suffer from.

WAYS OF MITIGATING THE SUFFERING OF A PATIENT

Table 1. Ways of mitigating the suffering of a patient

<table>
<thead>
<tr>
<th>Ways of Mitigating Suffering</th>
<th>Hospice</th>
<th>Internal department</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Physical presence</td>
<td>35</td>
<td>79.50</td>
<td>31</td>
</tr>
<tr>
<td>Nursing care – satisfaction of needs</td>
<td>42</td>
<td>95.50</td>
<td>56</td>
</tr>
<tr>
<td>Cooperation on patient’s care with family members</td>
<td>34</td>
<td>77.30</td>
<td>30</td>
</tr>
<tr>
<td>Providing contact with other patients (activation of patient)</td>
<td>26</td>
<td>59.10</td>
<td>25</td>
</tr>
<tr>
<td>Communication – discussion, small talks</td>
<td>44</td>
<td>100.00</td>
<td>50</td>
</tr>
<tr>
<td>Providing of spiritual service, discussion with priest, holy mass</td>
<td>36</td>
<td>81.80</td>
<td>29</td>
</tr>
<tr>
<td>Medications as prescribed by Doctor (analgetics, opioids)</td>
<td>36</td>
<td>81.80</td>
<td>52</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>6.80</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>257</td>
<td>273</td>
<td>530</td>
</tr>
</tbody>
</table>
Of 44 respondents working in hospices, the highest possible number, 44 (100%) said reduction of suffering by communication with a patient; 42 (96%) satisfaction of needs through implementation of nursing care; 36 (82%) spiritual mediation services; 36 (82%) through medications administration prescribed by a doctor; 35 (80%) alleviate patient suffering by physical presence; 34 (77%) alleviate suffering with the help of family members; 26 (59%) liaising with other patients; 3 (7%) hospice’s other ways of relieving a patient’s suffering including art therapy; music therapy; private prayer for a patient; accompanying a patient with a secure assurance of a physical presence by another person.

Of 57 respondents working at an Internal Department 56 (98%) implementing quality nursing care that meets a patient’s needs inhibits suffering; 52 (91%) administration of medication prescribed by doctor; 50 (88%) communications and interviews with sufferers; 31 (54%) alleviate patient suffering by physical presence; 36 (98%), 30 (53%) cooperation with family of a sick person; 29 (51%) by spiritual mediation services; 25 (44%) facilitate contacts with other patients; 0 (0%) other ways of alleviating suffering of a patient.

Figure 2. Most frequent ways of mitigating patient’s suffering

Of 44 respondents from a hospice facility 39 (89%) reported that most patients had pain relief from medication prescribed by a doctor pain relieving; 30 (68%) communication; 29 (66%) help performed by nurses; 27 (61%) physical presence; 25 (57%) spiritual mediation services; 15 (34%) meeting the spiritual needs; collaboration by family members when performing care for a patient; 5 (11%) mediation contact with others. The answer ‘other’ was not utilized in any of the surveyed hospice facilities.

Of 57 respondents from Internal Departments 45 (79%) nursing care provided to a patient alleviates suffering of most patients; 43 (75%) pain relief medication filed under doctor's prescription; 34 (60%) communication techniques; 23 (40%) physical presence; 21 (37%) collaboration with a patient’s family;
8 (14%) patient contact with other patients; 7 (12%) spiritual services; 5 (9%) meet the spiritual needs of a patient. One person answered that ‘other’ put a stop to suffering from an Internal Departments but does not say what.

**DISCUSSION AND RECOMMENDATIONS FOR PRACTICE**

Less than half of respondents who work at a Department of Internal Medicine, reported the presence of spiritual suffering of patients hospitalized in the department. Interestingly, we noted that in hospice facilities 57% of respondents, more than half, stated that spiritual suffering occurs in their patients. We believe that this is due to the fact that respondents from Internal Departments are dealing specifically with nursing care and with the satisfaction of basic biological needs of clients; the need for movement, nutrition, bowel habits, sleep, hygiene, breathing and need to be pain free. On the other hand, hospices focus on the needs of a patient in a spiritual area. Staff in hospices expend greater attention to these needs. Respondents from Internal Departments should take example from respondents from hospices and should consciously focus more on identifying and mitigating spiritual suffering. More than a half of respondents identified physical pain as the greatest suffering of hospitalized patients. The results also show that 73% of respondents from hospices are aware of ways to alleviate a patient’s suffering. The Internal Department respondents have less information on how to mitigate suffering of a patient than in hospice facilities; only 60% of respondents are aware of these methods of mitigation suffering. Respondents from all facilities agreed that the relieving from most patient’s suffering is drug application by pain medication. In second place is the alleviation of suffering by nursing care, third by communication.

We should, therefore, respect the uniqueness and complexity of humans and recognize all those inseparable areas. Nurses are often closer to suffering patients than doctors. Especially the burden of helping a suffering patient with whom they are in closer, more frequent and more opened contact lies on their shoulders. However, not all mitigation should be done only by a nurse. With cooperation of doctors, psychologists or priests (multidisciplinary team), individuals will complement each other, and thereby healthcare for a suffering patient will become integral and more complex and high-quality and the level and scope of provided care will improve.

A human is a unique, unrepeatable and original being. And as such, a human must be respected and we should try to understand the positive and negative aspects of his/her personality. It is therefore necessary that a medical staff to approach each patient individually and, especially, professionally, with dignity, respect, courtesy, friendliness and open hearts.

**CONCLUSION**

In an holistic context, a human is a bio-psycho-social-spiritual being, therefore we should respect him/her. A human is not merely the sum of biological, psychological, social and spiritual aspects, processes, and systems, but is an holistic entity; a complex whole being also experiencing a particular environment. Suffering is an integral part of every disease. Healthy people see their health as part of their life, as something granted and natural. But when they get ill, they discover a new dimension of perspective. From this point of view, suffering may have its positive side as well. Suffering reminds a human of his/her vulnerability and encourages responsible handling of each life. The adoption of human suffering, and concern for a suffering person, deepens and improves interpersonal relationships; consolidates friendship; human solidarity; leads to a greater humanity; and a humanity of sufferers, but also of their families and of all who try to help. Sufferers often can not help themselves, but other people can help them, primarily because shared suffering is better tolerated.

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