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Wound Care

By Craig Blinderman

I write this as a wounded healer.

During this global pandemic, many of us have watched patients, colleagues and family members get sick and die. We have been overwhelmed in the face of suffering we cannot alleviate and lives we cannot save. We have felt helpless in guiding families and friends grieving painful and often preventable losses. We have been traumatized in the process of providing care. We have been morally injured. The 7pm cheers that once sustained us have been replaced with questions like, 'how do you keep doing this?'

As I look back over the last 15 years as a palliative care specialist, an encounter early in my career with one patient and his family served as my own coming of age, or rite of passage, that qualified me to care for and accompany those facing death. More than that, I learned about the dual nature of healing and woundedness. How caregiving itself, when seen through the lens of interconnectedness, may actually be the answer to how we endure.

Dr. G was a professor of molecular biology. (*Characteristics have been altered to deidentify the patient*). He had been diagnosed with an inoperable, advanced skin cancer and opted not to pursue any disease-directed therapies, knowing the overall poor prognosis and not wanting to subject himself to a painful treatment course. When he told the treating team that he wished to hasten his death, they requested a palliative care consult, and the case was assigned to me.

On our first meeting in his hospital room, I saw a distinguished-appearing elderly man in hospital gown and a wool sweater comfortably sitting in bed. His room was adorned with awards, framed letters, and other honors celebrating his research career. Near the bed were photos of his family, though outnumbered and outsized by his accolades.

I remember feeling intimidated. I was a young physician, just out of fellowship, asked to evaluate this esteemed professor's request to hasten his death. I wondered if he had sensed my intimidation. Perhaps even saying to himself (or to his private attending physician): "Really? You send me this 30-something year old junior physician to decide if I can die when I want to?"

Within a short time in the room, he reviewed with me how he had accomplished everything he hoped to in life and had nothing else to look forward to. He had no unfinished life projects compelling him to live, and so he concluded that he should end his life and spare himself any future agony. Hard to know if this was a genuine retrospect, but he was earnest in describing this view of his life.

He was in no pain and surprisingly had no nausea or other distressing physical symptoms. He was weak, but he still had sufficient energy to walk in his room on his own. He could communicate effectively. His appetite had diminished but was still eating small amounts of food.

When I asked him what brought him joy, he acknowledged that he could experience temporary pleasure in the moment—from music to reading and conversations. His was an anhedonia for the future, believing it to have no value or purpose.

After my evaluation and discussions with my team and others, we concluded that he was not clinically depressed. His mind was clear, and he had full capacity to make decisions. He had accomplished all that he hoped to and therefore felt he had no good reason to continue to live.

He also feared that whatever time remained would be filled with suffering and loss of dignity. Indeed, perhaps this was the real propellant for his decision to hasten his death.

While we were not legally permitted under state law to help him end his life through a lethal overdose, and he was not explicitly asking for this, we discussed other alternatives, including stopping all medical treatments not directed toward his comfort, hospice care at home, and voluntarily stopping eating and drinking. He was interested in pursuing this last option, believing that it would give him a sense of control over his dying and not prolong his terminal phase of cancer.

When I visited him the following morning, I noticed that he had eaten most of his breakfast. "Tomorrow," he said, "I'll stop eating and drinking tomorrow."

This pattern repeated for a few days.

A generous reading of his indecision is that he now had a "way out" and this gave him some peace of mind, so the urgency dissipated. He could postpone or defer the timing of his death, which gave him a sense of control. I also wondered whether his indecision was like a crack in his resolve, a fissure that revealed his ambivalence.

In conversations with his family, I found additional insights into his psychological situation. They were impatient with his indecision and even voiced their resentment of his self-centeredness. The emotional distance between my patient and his wife and children was a *familiar* distance - one that I had experienced in my own family - where the space of silence is filled with judgments and old sores. Where the garments of filial love are sewn not from tender cloths, but contain coarser fabrics, with threads of guilt and discipline.

Had the professor considered how hastening his death would affect his wife, his children and his grandchildren's lives, their emotional needs, concerns, and plans? I wondered, was he the kind of researcher who would stay late at the lab, or in his office finishing a grant proposal that is due, instead of attending a child's basketball game? Placing his needs above those he no doubt loves?

Long held resentments from my own childhood, old wounds that had not completely healed, were being stirred up in me. The feelings intensified during my conversations with his family. I could imagine that perhaps their lives too may have been painfully shaped by rigid expectations, harsh discipline, persistent disappointments, and narratives of "success."

I asked Dr. G, "Have you thought about how hastening your death might impact your family and your relationship with them?" He looked at me and wondered out loud, "This must seem rather selfish of me?" He seemed to not have thought this part through completely. I acknowledged and normalized his feeling and then remained silent.

I wondered if Dr. G appreciated how this lapse in consideration separated him from connectedness. I certainly appreciated the lesson. It felt like a moment of clarity for me. Chronic feelings of antipathy and anger towards my parents had begun to soften. To be sure, years of therapy had already helped unravel and explore these feelings, but my witnessing this man, with this unique family and set of circumstances, seemed to illuminate my own psychological struggle. Becoming his palliative care doctor had exposed the dynamic intersection that medicine offers. In this intersection is the possibility of healing—of making some part of us whole again.

A few days after our conversation he was discharged to a local hospice facility. He never developed the severe pain or agony that he feared and died comfortably several weeks later. Over the months and years following his death, I had cultivated a more connected relationship with my own parents, letting go of past resentments and finding forgiveness in its place.

This dichotomy of being both wounded and a healer can be traced to the mythological origin of Western medicine. Chiron, the great centaur and teacher of Heracles, Jason, and Perseus, was also a healer. He taught the healing arts to Asclepius, the god of medicine, whose followers, the Asclepiades, taught Hippocrates. Chiron was also famously wounded. In one story, a variation of an encounter with centaurs during Heracles' 4th labor, one of Heracles' poisoned arrows inadvertently punctures Chiron's flesh. As an immortal, his wound would not kill him but instead be a reminder of his unique and personal suffering.

Carl Jung described Chiron as the "wounded healer," the archetype for the modern therapist or healer. Jung suggested that enduring a wound may be the best training for a physician. A healer who has experienced illness or suffering would be capable of the compassion and vulnerability needed in the most crucial moments in providing care. Wounded healers understand that they and their patients inhabit similar landscapes of suffering, though not equivalent, there are places for connection.

When I look back at my experience caring for Dr. G, I learned that I was tapping into my own wounds—my childhood and adolescent narratives that had been a source of disquiet for me over the years. I could see my patient's family's suffering in clearer contours, similar to the lines drawn around my own pain.

The lessons from that experience continue to resonate during this pandemic: we are connected through our shared wounds. When we allow our shared vulnerability and woundedness to

inhabit the space of our caregiving, we connect more deeply, palliating our own pain in the process.

Our interconnectedness may be the secret to our endurance.

Craig D. Blinderman, MD, is the director of the Adult Palliative Care Service at Columbia University Irving Medical Center/New York-Presbyterian Hospital.