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Attitudes of doctors and nurses to suffering

Ewa Wilczek-Rużyczka, Elżbieta Zajkowska, Katarzyna Wojtas

Summary

Introduction. The world of suffering is extremely varied in its structure, dimensions and consequences. It refers to each of us in a different way according to our personal sensitivity and the structure of personality. However, it often happens that while experiencing suffering, we feel crushed with its suddenness and strength. There are many attitudes to suffering. Everybody suffers in their
own unique way, which is conditioned by one's individual hierarchy of values.
Aim. The aim of this research was to get to know the attitude of doctors and nurses to their own and other people's suffering and to recognize those aspects of life which have an influence on creating those attitudes in groups under research. In connection with all this, some research hypotheses were proposed assuming adoption of positive attitudes to suffering in which the emotional component and relation between own experience of suffering by doctors and nurses and subsequent attitudes of therapeutic team predominate.
Material and methods. To conduct the research a questionnaire which contains questions about demographic and problematic character referring to opinions of own suffering experienced by those under research and attitude to the patients was individually elaborated. The research was conducted in a group of 40 doctors and 40 nurses.
Result. As a result of the research, the positive attitudes to suffering have been proved among both doctors and nurses. However, among nurses, some predominance of the emotional component has been noticed. There is predominance of the cognitive-emotional component over the behavioural in the whole group under research.

suffering / attitude / pain

INTRODUCTION

The authors understand the concept of attitude as a constant structure (or a predisposition toward creating this structure) of cognitive and emotional processes and a tendency to manifest behaviours, which show one's attitude toward a subject. [1] The structure of attitude means its main components, which may be examined: a cognitive element, the tendency toward some behaviours, and emotional attitude. The cognitive component of an attitude comprises two elements: matters being learnt currently and those learnt previously. Self-learning and educational mechanisms are an important factor of this component. [2] The emotional component includes positive, negative and neutral attitudes toward the subject while the behavioural factor emphasizes the types of behaviour and takes into consideration relatively constant reactions to the specified stimuli [2].

Working with suffering people requires inborn personal predispositions. One might even risk a suggestion that those are extraordinary

Ewa Wilczek-Rużyczka[1], Elżbieta Zajkowska[2], Katarzyna Wojtas[1]:
[1] Department of Clinical Nursing, Institute of Nursing and Obstetrics, Faculty of Health Sciences, Medical School, Jagiellonian University, Cracow, Poland, [2] Town Hospital in Myślenice, Intensive Cardiology Care Unit. Correspondence address: Ewa Wilczek-Rużyczka, 25 Kopernika Str., 31-501 Cracow, Poland; e-mail: ewaroz0@poczta.onet.pl

skills. The members of a therapeutic team are expected not only to be a source of professional knowledge considering pain relief but they should also be able to accompany and understand their patient and give hope proportional to the health status and abilities of a suffering individual. Carers must be aware that physical suffering influences the mental spheres and often leads to negative emotional reactions e.g. frustration, anger and mutiny. Those behaviours result from the patient's sense of helplessness and the fact that patients don't accept their suffering. That is why the above mentioned skill of understanding others' behaviours and avoiding judging people as "good" or "bad" patients becomes so important. It seems relevant to underline the philosophical aspects of suffering by M. Scheller. The author emphasized that all kinds of suffering are "only subjective mental reflections and correlates of the victim's objective processes" regardless behaviours manifested by the suffering person. [3]. Patient's suffering poses many questions to be answered by one's family members e.g. what it is, what is the source of suffering and finally what is the meaning of it. At the beginning it seems that suffering is just a simple question "why". It reflects the mutiny, lack of approval, a kind of complaint. It is also an absolute loneliness; one is immersed in the painful "why", turned from the world and other people. A human-being suffers alone and is unable to find any reasonable explanation for the experienced suffering.

Lukas paid special attention to the psychological aspect of suffering. According to Lukas, one doesn't suffer because of a normal situation, in which she or he found himself, but because there is no sense in that. People suffer not because they couldn't fulfil their needs but because they can't answer why those needs couldn't be satisfied. [4] Meanwhile, Frankl emphasizes that only humans can be related to as those suffering. Suffering means manifesting an attitude toward things that happen to a person and are painful. However, it also means that people are not ruled by their fate, they aren't shaped by it, grow above their fortune and form it on their own. If human suffering is understood that way than Frankl's credo, which was his leading theory in the therapeutic practice, doesn't seems to sound paradoxical. It says that the task of a therapist is not to deprive people of suffering but to teach them how to manage it [5].

It is rather impossible to teach a person how to accept suffering and to show the meaning of it. A suffering individual must rather develop his/ her attitude to it, which is always related to some personal decisions and personal entrusting. It is impossible to predict one's behaviours in a situation causing pain, weakness, disease or sadness. It is not known what must happen inside a man so he or she can overcome pain, despair, sadness or fears. And the way the man suffers affects his or her whole life. Those who discover the sense of suffering make their whole life meaningful and change the world to be a better place [5].

Those issues are significant for both doctors and nurses regardless the place they deliver medical and nursing care. That is why this study aims at discovering the attitudes manifested by nurses and medical doctors toward suffering and defining the sources and factors forming those attitudes.

MATERIAL AND METHODS

The research tool used in this study was developed on the basis of the Attitudes toward Suffering Questionnaire created in the Department of Religion Psychology, the Pontifical Academy of Theology in Cracow. It comprises 36 questions: 1 is an open question, 18 are half-open and the remaining 17 are closed questions. It consists of socio-demographic and research parts regarding the attitudes of nurses and doctors toward their own suffering and the subjects of their care i.e. their suffering patients.

The study group comprised of 40 doctors and nurses working in the Public Health Care Centre in one of towns in Małopolska. The respondents worked in the following units: surgery and orthopaedics, internal diseases, intensive cardiology care and dialysis. Female participants comprised the vast majority of the study group (67%). As far as the age was concerned, the biggest subgroup included individuals aged from 28 to 35. The mean period of professional work was 12.3 and 16.6 years in the group of doctors and nurses, respectively.

RESULTS

The ability of helping those suffering, accompanying them and manifesting positive attitudes toward the subjects of the provided care as well as the fact of suffering itself, are due to individual predispositions, undoubtedly. The term "empathy" was correctly understood by 87.1% of doctors and 57.7% of nurses (p=0.002) contrary to 12.9% of doctors and 38.46% of nurses, who had different ideas of empathy (p=0.005). Table 1 presents those data.

Table1. Understanding the term of empathy

Answer	Doctors	Nurses	P value
correct	87.1%	57.7%	p = 0.002
wrong	12.9%	38.46%	p = 0.005

According to the respondents, topics considering problems of another man's suffering were rare during their education, and 32.5% of doctors and 15% of nurses said they never talked about those issues (p=0.03). Table 2 shows those results.

Table 2. The presence of topics related to suffering during studies and trainings

Answer	Doctors	Nurses	P value
Lack of this topic	32.5%	15.0%	P = 0.03

Respondents' experience of suffering and feelings accompanying it.

Mother's or father's disease was the first contact with suffering for 52.5% of nurses and 20% of doctors while 17.5% of doctors and 2.5% of nurses said they met suffering for the first time while taking care of individuals not related with them. Table 3 includes data regarding this question.

Table 3. First contact with suffering

Answer	Doctors	Nurses	P value
Mother's or father's disease	20.0%	52.5%	p = 0.001
Stranger's disease	17.5%	2.5%	p = 0.01

According to the respondents, 65% of doctors and 62.5% of nurses, they talked about suffering only when it was necessary. Open discussions in that field were led by 27.5% and 32.5% of doctors and nurses, respectively.

Suffering of the closest person was the main factor responsible for forming one's attitude toward suffering among 40% of nurses and 25% of doctors. Thirty percent of nurses and 25% of doctors declared their attitude was a consequence of religious upbringing. None of the respondents formed the attitude toward suffering using the mass-media. In the opinion of 40% of nurses and 28% of doctors the Bible allows to develop the attitude towards the discussed subject while 28% of doctors said they had no reading-matter, which could influence their behaviour. The role of faith in this matter was underlined by 55% of nurses and 47.5% of doctors.

As far as the ability of suffering for someone was concerned, 72.5% of doctors and 67.5% of nurses said they were ready to do it, which is a positive proof of their sensitivity and altruism. Some nurses (22.5%) and doctors (12.5%) declared they would save the life of another person with whom they had no emotional bound.

The nurse and doctor respondents think about their own suffering only sometimes (65% and 50%, respectively). Statistically significant difference was observed for the following answer: "I think about my own suffering once a year or less often" (p=0.003). The answer "I often think about my own suffering" was within the limit of significance (p=0.05) (Tab.4).

The most difficult elements of suffering for most respondents (60%) included the sense of helplessness, pain (22.5% of nurses believed this is an important problem while in the group of doctors only 5% had that point of view (p=0.01)), the feeling of uncertainty and awaiting, fear and anxiety was noted by 12.5% of doctors (Tab. 5).

Table 4. Thinking about own suffering

Answer	Doctors	Nurses	P value
often	7.5%	20.0%	p = 0.05
seldom (once a year or less often)	27.5%	5.0%	p = 0.003

Table 5. The most difficult feeling in my own suffering

Answer	Doctors	Nurses	P value
pain	5,0%	22,5%	p = 0,01
uncertainty and awaiting, fear, anxiety, prolonging suffering	12,5%	0%	p = 0,01

As far as positive changes in one's life after the contact with one's own or another man's suffering was concerned, 5% of doctors and 22.5% of nurses said they "appreciated their life" (p=0.01) while 15% of doctors and 2.5% of nurses added they "became sensitive to other people suffering or this suffering developed the need for fight in me". These were the examples of the respondent's answers. The difference regarding the choice of those responses turned out to be statistically significant (p=0.02) (Tab. 6).

Table 6. The influence of experienced suffering on the attitudes

Answer	Doctors	Nurses	P value
I appreciate the life	5.0%	22.5%	p = 0.01
• I became sensitive to other people suffering • I accept things I can't change The need for fight	15.0%	2.5%	p = 0.02

Helping the suffering

When asked what they would expect while suffering, 37.5% of doctors and 22.5% of nurses would expect the presence of another person. However, words and gestures of comfort wouldn't matter for 2.5% of the respondents. Understanding would be a significant help for 10% and 25% of doctors and nurses, respectively (p=0.04) (Tab. 7).

Table 7. Expectations in one's own suffering

Answer	Doctors	Nurses	P value
understanding	10.0%	25.0%	p = 0.04

The discussed forms of help were expected from the closest family members. This source of support was mentioned by 40% of all the respondents. Significant group of participants would seek comfort in prayer and God as it was declared by 33% of doctors and 20% of the nurses. Only 17.55 of the nurses said they would turn to the Mother of God for help (p=0.003) (Tab. 8).

Table 8. Expected source of help in one's own suffering

Answer	Doctors	Nurses	P value
Mother of God	0%	17.5%	p = 0.003

As far as a form of support was concerned, 32.5% of the respondents believed it should be a concrete form of help while understanding, conversation and the presence of another man were less important. The participants were asked to define the hierarchy of support forms giving them a rank ranging from 1 to 5. According to the respondents, commitment in constant care of a patient would be the most important and needed form of help (61.25% of nurses and doctors). Nursing care of bedridden patients was the second most frequent answer (48.75%). Conversations (38.75%) and material help (52.5%) were respectively the third and fourth most often mentioned forms of help. Being a volunteer was classified at the last, fifth position (58.75% of the respondents).

The participants of this study were asked to characterize suffering and they pointed to two different aspects of suffering i.e. physical and psychical suffering, which may concern many spheres of human life. According to 65% of the nurses and 45% doctors, the presence and the attitude directed towards accompanying the patient were the most desired forms of help (p=0.03). None of the respondents would recommend the phone helpline as the most effective form of support (Tab. 9).

Table 9. The most effective form of help for people suffering psychically

Answer	Doctors	Nurses	P value
Be with them	45.0%	65.0%	p = 0.03

EVALUATION OF THE PRESENTED COMPONENTS DONE BY THE RESPONDENTS

The emotional component

Analysis of the emotional component of the attitude included assigning it questionnaire items and key answers, which would describe this aspect. The answers given by nurses and doctors were presented in the form of quantitative analysis. Most answers were chosen by a larger number of nurse than doctor respondents. Only the first one, concerning pain experience, was an exception i.e. it was chosen by 22.5% doctors and 15% of nurses. Both studied groups i.e. nurses and doctors (60%) believed that helplessness was the most difficult feeling while suffering. The chi-square analysis comparing the frequency of responses between both groups revealed

no statistically significant difference. However, nurses scored higher than doctors, which may suggest that nurses have a stronger tendency toward emotional behaviours. It is possible that a statistically significant difference would be observed if the study group was bigger.

were assigned to it with only one specific answer. Table 12 shows small predominance in the indications obtained from the nurses. However, further statistical analysis didn't prove any significant difference between the study groups. Table 12 presents the frequency of indications to the following answers.

Table 10. Emotional component of the attitude toward suffering in the respondents' opinion

specification — Total number of the participants 80	Respondents			
	doctors		nurses	
	number	%	number	%
Suffering means experiencing pain	9	22.5	6	15.0
Suffering is helplessness	24	60.0	24	60.0
Suffering is an internal mutiny	9	22.5	13	32.5
Loneliness is the easiest form of suffering to deal with	11	27.5	15	37.5
Suffering known only to family	20	50.0	27	67.5
Attitude toward suffering: fear	19	47.5	21	52.5
Commitment is a form of help in suffering	19	47.5	24	60.0

The cognitive component

Survey questions were also assigned to assess the cognitive component (one specific answer). First four points in the cognitive aspect were chosen more frequently by nurses than by the doctors, contrary to the following three ones. The analysis of the obtained data didn't result with the value of statistically significant difference (p=0.35). Table 11 presents the distribution of responses in the studied groups.

Summarizing the above mentioned results of analysis, a predominance of the cognitive-emotional component over the behavioural factors was observed in both study groups i.e. doctors and nurses. The groups were compared using the chi-square test, however no statistically significant difference was obtained in the discussed aspects (Tab. 13).

Table 11. Factors influencing the cognitive component of attitudes toward suffering

specification — total number of the participants 80	Respondents			
	doctors		nurses	
	number	%	number	%
suffering of a close person	10	25.0	16	40.0
faith	19	47.5	22	55.0
understanding and the will to help	10	25.0	15	37.5
insufficient number of classes during the studies	22	55.0	27	67.5
suffering influences the growth	38	95.0	36	90.0
hope gives strength in the fight against diseases	29	72.5	25	62.5

The behavioural component

While considering the behavioural component of attitudes toward suffering, survey questions

In the opinion of 72.5% of doctors and 80% of nurses, suffering is related to negative feelings. Most respondents (80% of nurses and doctors) declared the attitude toward suffering full of un-

Table 12. Factors influencing the behavioral component of attitudes toward suffering according to the respondents

specification — total number of the participants 80	Respondents			
	doctors		nurses	
	number	%	number	%
Open discussion about suffering	11	27.5	13	32.5
consent to suffering if that would save someone's life	5	12.5	9	22.5
suffering causes the question "why me?"	6	15.0	12	30.0
when suffering I would expects the presence of other people	15	37.5	9	22.5
help expected from a doctor/ nurse	5	12.5	4	10.0
suffering should be minimized in a dignified way	23	57.5	24	60.0
personnel offer help	14	35.0	12	30.0

Table 13. The sum of scores obtained in the discussed components.
N — the number of respondents, SD — standard deviation

parameters	Doctors/ SD	Nurses/ SD
emotional component	2.775 ± 1.23	3.250 ± 1.08
cognitive component	3.750 ± 1.21	4.000 ± 1.20
behavioral component	1.975 ± 1.16	2.075 ± 1.25
N	40	40

derstanding. Despite the episodes of aggression shown by patients, 62.5% of doctors and 70% of nurses were willing to continue helping those who suffer. The need for deeper understanding of topics related to suffering, which reflected the positive attitude, was declared by 85% of nurses and 67.5% of doctors. The vast majority of the participants would take positive actions toward suffering present in the world.

DISCUSSION

Suffering, pain, discomfort… When asked about the frequency of their reflection concerning those feelings, most people would wonder where this question came from. Nowadays people, lost in their everyday duties and tasks, don't think about those unpleasant things. It is possible that proportions between the chase for new professional successes and money and deeper reflection regarding those negative emotions and difficult situations changes with one's age and life experience. Maybe it's unfair to judge badly all those people who refuse to accept that human life is not only a chain of success but also suffering. However, it seems that they should at least be aware of the fact that suffering is real.

It is very likely that the process of making suffering in human life unreal is promoted by mass-media, educational and upbringing models, which treat this topic marginally. Therefore, escaping such reflections may be a kind of defensive mechanism from everything that is ugly, difficult and uncomfortable in life. But why does that happen? The answer seems to be obvious. When we don't know something or don't understand it, we become cautious. We prefer to be safe or convince ourselves that this problem doesn't exist. Maybe this reaction is natural to something exceeding our schematic and organized picture of reality in which phenomena like suffering, pain or death are discussed only "on the occasion".

But one must remember that understanding the world in the category of joy and realization of personal plans becomes a trap, for suffering comes upon us or our relatives sooner or later and it is very difficult to confront this situation then. Suffering is an experience not only in the physical dimension but it often coexists with the psychic sphere, which is much more difficult to manage e.g. chronic disease or cancer. Medi-

cal personnel i.e. doctors or nurses have tasks like accompanying those suffering and helping them, inscribed in their fundamental professional duties.

Medical literature includes papers discussing those issues and specific attitudes toward suffering people. It seems relevant that the analysis of attitudes toward the suffering includes historical and cultural aspects of the environment. "Cultural factors predict the attitude toward suffering and behaviours in specific situations" [6]. Walden-Galuszko says that pain experienced in the psychic sphere isn't treated unequivocally. " Different cultures, traditions and historical periods assessed pain in various ways – sometimes it was evil and must have been destroyed, sometimes it was a symptom of courage or element of character, an "educational" factor making people sensitive to the needs of others or a life necessity, which must have been accepted" [7]. The author also presents the stages of pain and describes suffering as a complex phenomenon implicated by emotional reactions based on fear and anger etc.

Personal traits and methods of managing pain are also important when suffering is concerned. Therefore, whether one seeks help or the contrary, depends on how pain is perceived by one's surroundings.

The ability of understanding the meaning of being with the suffering is a very complex and difficult art, which fully reflects the holistic character of care provided by the therapeutic team. The attitude presented by A. Schweitzer and C. Saunders and described by B. Stelcer may be used as an example [8]. Schweitzer as a priest, doctor and philosopher took every possible action in order to alleviate human suffering. A similar pattern of interventions was chosen by the well known C. Saunders. She decided for medical education so as to learn about pain and methods of its relief. She emphasized a multidimensional character of the experienced pain and underlined that "if a patient is heard and understood, the fear will decrease, therefore the subjective sense of pain as well as the requests for analgesics will be weaker" [p.54]. This pattern of thinking finds its reflection in the study group. The participants also believed that their presence and being with patients as well as showing empathy are indispensable when helping those suffering (this attitude of care for another person and willingness to alleviate one's suffering comprise the fundamentals of the hospice movement). B. Czerska presents a similar view on the essence of empathy when taking care of the suffering. [9] "The presence of an empathic doctor able to understand the situation guarantees the intimate sense of being understood" [9]. That's when the therapeutic relation and the sense of security starts. Interesting results were presented by Leppert et al., who studied the discussed subject among doctors and medical students [10]. These authors asked the respondents to define suffering and pain. The participants usually were unable to separate those terms and defined them as unpleasant feelings, discomfort. Others defined pain as a mental experience, while suffering was understood by them as a combination of physical pain with spiritual and mental experiences. There were also opinions saying that "pain and suffering are experiences fixing their whole attention to them and making normal life impossible". Our findings are consistent with those above mentioned ones. Our study group also believed that suffering comprises both, the mental and physical spheres.

A short presentation of various authors' opinions on suffering and the attitude toward the subject of care proves that this topic is an important issue for the medical personnel. Being aware of suffering and the necessary confrontation with it should be reflected in educational programs for future graduates of medical schools.

Therefore, maybe the opinions that it is impossible to teach a person the attitude of accepting suffering and to show one its meaning are not fully true? If a person taking care of a suffering individual shows the acceptance for suffering, then the career will help the caretaker to reconcile oneself with one's life situation.

CONCLUSIONS

1. Both doctors and nurses show positive attitudes toward suffering. There is no significant difference in their attitudes though some predominance of the emotional component is observed among nurses.

2. A predominance of the cognitive-emotional component over the behavioural one was noted in the whole study group.
3. Personal suffering of the respondents related to their attitudes toward the suffering. Moreover, personal suffering allowed the participants to appreciate life.
4. The following factors were the most important ones shaping the attitude toward suffering among the respondents: suffering of the closest people, faith, and religious upbringing.
5. The most difficult feeling connected with suffering was helplessness. Nurses also indicated pain more often than doctors.
6. When experiencing suffering the respondents would expect the presence of another man in the first place. More nurses than doctors would also expect understanding.
7. The most adequate form of help for those who suffer mentally is a constant presence. This solution was indicated by nurses more frequently than doctors.
8. Most respondents emphasized the important role of hope in the experience of suffering. More nurses than doctors believed it revitalized the faith in healing.
9. In the opinion of the respondents, school and university educational programs underline the subject of suffering much insufficiently.

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