Comfort and Medical Care

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In medicine today the word *comfort* has fallen on hard times. This is unfortunate, for comfort has a rich history of meanings that aptly describe medicine's traditional goals. Understood in its original richness, comfort reopens to view the goals that have been eclipsed by scientific, technological, and bureaucratic changes in medicine's recent history, but which family medicine considers essential to its task. Parallel to the expansion of the scientific, technological, and bureaucratic dimensions of medicine, however, there has been a shrinkage in our common understandings of the meaning of the word *comfort*. The word is now a shell of its former self, and has lost its power to arouse the enthusiasm of many physicians. Restored to health, comfort reinforces important aspects of family practice—aspects that take on added significance because of the very forces that have contributed to the word's decline.

Announce to a meeting of physicians that the physician's job is to comfort the sick, and encounter yawns of boredom. To many modern physicians, Thomas Percival's classic assertion, that "the physician should be the minister of hope and comfort to the sick,"[1] merely reflects the limited powers of medicine in his day. Then, comfort was all the physician had to offer; now, we offer realistic hope for cure.

Comfort has been redefined as the mission of others. It has been split off from medicine's technical and curative tasks, and is seen by many as a shallow substitute for curative powers that (unlike those powers) can be delegated to others without materially diminishing the physician's professional competence. On the hospital ward, it appears in the form of a nurse smoothing a pillow, giving a backrub, and speaking gentle words of encouragement. Listen for the word *comfort* in a medical student's case presentation, and hear that after resuscitation efforts failed and the house officers were gone, the student and the chaplain stayed behind to comfort the family.

Comfort has been redirected to patients whom medicine cannot help in any other way, that is, whom medicine can comfort *only*. "To comfort the patient" has acquired the connotation of a last resort in cases of therapeutic impotence, as expressed in the maxim: "If we cannot do anything else, we should at least comfort the patient."

At best, comfort is pursued as an important part of compassionate care for the dying, but is otherwise seen as a dispensable item on a crowded technical agenda. At worst, it is seen as a relic of medicine's inept past, an obligatory platitude in the prefaces of medical textbooks, appearing on page *i*, never to be seen again.

Contrary to these shrunken modern remains, which suggest passive resignation to misfortune, comfort historically has embraced a robust cluster of meanings that denote vigorous responses to illness and suffering. Comfort is derived from the Latin *confortare*, meaning "to strengthen." The first definition of the verb *comfort* in the *Oxford English Dictionary* is "to strengthen (morally or spiritually); to encourage, hearten, inspirit, incite." Subsequent definitions include "to lend support," "to strengthen (physically)," "to strengthen (the bodily faculties, organs, etc), to invigorate, refresh," and "to minister delight or pleasure to; to gladden, cheer, entertain." Only after giving these meanings does the *Oxford English Dictionary* list the meaning that remains in current usage: "To soothe in grief or trouble; to relieve of mental distress; to console, solace."

In the Bible, the Hebrew and Greek words translated as comfort span the same range of meanings. "To be of good comfort" means, in addition to taking solace and consolation, "being refreshed or braced up," and "being courageous and hearty." "To comfort" means to speak kindly, to help, and to call or summon to one's side.

Percival was right to identify the physician with the bringing of comfort. He could rightly claim that in bringing comfort physicians brought more than conso-

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lation; they also imparted to their patients an empowering and inspiriting vitality.

Percival is still right. To appreciate why, note the aspects of relationship and social solidarity that figure prominently in the dictionary and biblical meanings of the word.

Giving comfort presupposes the act of entering into a relationship. Illness, on the other hand, confronts people with the threat of isolation, evoking fears of abandonment or extrusion by the group. The sting of illness is not simply death. It is also the specter of broken relationships—the disintegration of one's social world precisely when one feels most vulnerable to dangers from within and from without.

Caregivers counter these threats by affirming the patient's continuing relatedness. *This is comfort: summoning to the side of the sick person a reinvigorated sense of social connection.* Whatever else medicine may have become as a result of technological change, it continues to be a set of institutional and interpersonal forms for communicating to people the assurance of continuing relatedness to others, despite the isolating or debilitating effects of illness. This assurance is embedded in each of the connotations of comfort in the dictionary and biblical meanings. It contributes to the healing efficacy of all medical interventions, whatever their technical sophistication, as testified by the extensive literature linking health and social support.[2,3]

Professional caregivers do not act alone, however. The challenge for physicians is to identify and mobilize the many social, cultural, and communal resources that nourish health. Physicians form part of this environment, but a rich notion of comfort is a reminder that professionals are only part of the picture when it comes to maintaining or restoring health. They are more effective when they catalyze the therapeutic potential of the patient's own caring community.[4-6]

These reflections lead to an ironic conclusion. Old-fashioned ideas such as comfort take on new relevance just when many would argue that modern medicine's socioeconomic realities are making traditional humanistic ideas obsolete. A rich understanding of comfort is especially pertinent at a time when medical services are being doled out ever more grudgingly to the indigent and the elderly, and earlier discharge from hospitals for the diagnostic-related-group bound patient is transforming medical practice. It is still too early to say whether these patients are victims of politically conservative zealotry and the profit motive, or the beneficiaries of a budget-induced discovery that—for some forms of medical care at least—less is better.[7,8]

Either way, we need to renew our confidence in the nonprofessional sources of health and well-being that stem from people's nourishing participation in communities, such as the communities of faith, work, and family. This view does not set aside professional competence and technique, but it does place them in a wider context. Professionals are called to be advocates for the health of those communities as well as dependable allies of those who feel cut off from their communities during periods of illness and disability. Family physicians have traditionally played this advocacy role, both in practice and in medical education. To the extent that the foregoing discussion is persuasive, they should play it even more vigorously in the future.

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