

Chapter 37

Suffering, Hope, and Healing

Jack Coulehan

What Is Suffering?

The words “pain” and “suffering” are so often used together in clinical practice they sometimes seem to merge into a single concept, with clinicians simply referring to “pain-and-suffering.” Writing in the early 1980s, Eric Cassell bemoaned the fact that the medical literature contained very few studies that specifically addressed suffering, although there were hundreds of reports that focused on all aspects of physical pain (Cassell 1982). Since then, the study of human suffering has advanced considerably, in large part due to the development of palliative medicine as a clinical specialty. Nonetheless, controversy about the primacy of pain and other physical and emotional symptoms as the causes of suffering in illness remains. Some observers argue that such symptoms are the central feature of suffering, even though emotional and cultural factors also play a role (Wall 1999). Most, however, focus their attention on existential factors not directly dependent on the experience of physical pain (Kellehear 2009).

Suffering represents a dimension of personal distress that goes far beyond physical, or even emotional, pain. There is no consensus on a single, precise, and comprehensive definition of human suffering (Wilkinson 2005). However, virtually all definitions focus on one or more of a cluster of related characteristics. According to Eric Cassell, suffering occurs when illness or other circumstances threaten a person’s intactness (Cassell 2004). He defines the concept as “a specific state of severe distress induced by the loss of integrity, intactness, cohesiveness, or wholeness of the person, or by a threat that the person believes will result in the dissolution of his or her integrity” (Cassell 1995). An Irish palliative care physician, substitutes the term “soul pain” for suffering and defines it as “the experience of an individual who has become disconnected and alienated from the deepest and most fundamental aspects of him or herself.” The psychotherapist Viktor Frankl identifies suffering with perceived loss of meaning in one’s life (Frankl 2006). Arthur Frank views suffering as a person’s experiential response to the loss of his or her sense of being “myself,” which leads the person to mourn for their previous identity (Frank 2001). In an editorial entitled “Suffering and healing – our core business,” George concludes that suffering results from an attack on “integrity of, or sense of, self, dissociation or otherness, a loss of dignity – the draining of events upon one’s sense of worth or value” (George 2009).

J. Coulehan, MD, MPH (✉)
Center for Medical Humanities, Compassionate Care, and Bioethics, Stony Brook University,
Stony Brook, NY 11794-8335, USA
e-mail: jcoul44567@aol.com

Thus, the core concept of suffering involves dissolution, alienation, loss of personal identity, and/or a sense of meaninglessness. The onset of severe symptoms triggers suffering when a person interprets these symptoms as threats to his or her selfhood: What is happening to me? Will my future be cut short? Can anything be done? This existential crisis may occur even when the illness is not life-threatening (e.g., unexplained and uncontrolled migraine headaches) or, if threatening can be treated successfully (e.g., pneumonia or early-stage cancer). In these cases, much of the suffering resolves when the patient realizes that the condition can be cured or at least integrated into the patient's self-identified life narrative.

Such a resolution cannot occur when the illness is progressive or terminal. Thus, in palliative medicine, clinicians distinguish between the physical pain and other symptoms of seriously ill and dying patients, and their existential suffering. The former obviously contribute to, and interact with, the latter. In most cases severe symptoms can be substantially relieved by medical treatment, and this, in turn, may well reduce suffering; e.g., symptom-free patients are better able to address their suffering by generating hopefulness and participating in meaningful relationships. Cicely Saunders coined the term "total pain," equivalent to *pain plus suffering*, to indicate the comprehensive distress or suffering of dying patients (Saunders 1984). Even with complete symptomatic relief, however, patients still experience the suffering component of total pain.

Phenomenology of Suffering

We can learn much about the phenomenology of suffering from the accounts of writers who carefully observed and described their own experiences. For example, the late nineteenth century French novelist and playwright Alphonse Daudet wrote a series of notes documenting his suffering from *tabes dorsalis*, a form of tertiary syphilis (Daudet 2002). Here are three examples of Daudet's reflections:

Very strange, the fear that pain inspires these days – or rather, this pain of mine. It's bearable, and yet I cannot bear it. It's sheer dread: and my resort to anesthetics is like a cry for help, the squeal of a woman before danger actually strikes (p. 9).

Pain in the country: a veil over the horizon. Those roads, with their pretty little bends – all they provoke in me now is the desire to flee. To run away, to escape my sickness (p. 45).

I've passed the stage where illness brings any advantage, or helps you understand things; also the stage where it sours your life, puts a harshness in your voice, makes every cogwheel shriek. Now there's only a hard, stagnant, painful torpor, and an indifference to everything. Nada! Nada! (p. 65).

These excerpts reflect three responses to suffering that in Daudet's case occurred sequentially: the cry for help, the desire to flee, and, finally, the development of indifference and immobilization.

Anna Akhmatova, a great twentieth century Russian poet, spent most of her life victimized by official Soviet disapproval. Her husband was executed, her son imprisoned, and for decades Akhmatova endured a marginal hand-to-mouth existence, her poetry suppressed by the government. After her son was arrested in 1938, Akhmatova, along with hundreds of other women, waited in line every week for 17 months at the prison gates, hoping to obtain some news about her son's fate. She later wrote a long poem entitled "Requiem," as an expression of her suffering during that period (Akhmatova 2004):

Today there's so much I must do:
Must smash my memories to bits,
Must turn my heart to stone all through,
And must relearn how one must live (p. 137).

Admit it—fighting back's absurd,
My own will just a hollow joke,
I hear my broken babbling words
As if some other person spoke (p. 140).

Do what you please, take any shape that comes to mind,
 Burst on me like a shell of poison gas,
 Or creep up like a mugger, club me from behind,
 Or let the fog of typhus do the task (p. 139).

These excerpts evoke three stages of suffering somewhat different from Daudet's. The first communicates a recognition that action is preferable to passivity. In this case, the action is not a cry for help, perhaps because such an outburst would have been useless in Soviet Russia. Instead, Akhmatova commits herself to life changes – smashing memories, turning her heart, relearning how to live. In the next excerpt, she gives up. The poem turns passive and cynical. In the final stage, Akhmatova appears to welcome annihilation. Her numbness mutates into a strong, yet still confrontational, desire for nothingness.

Poet and novelist D.H. Lawrence provides a third example. As he was dying of tuberculosis in late 1929 and 1930, he wrote and rewrote “The Ship of Death,” a poem that serves as a form of *ars moriendi*, a testament to his suffering and preparation for dying. One of Lawrence's central metaphors imagines the dying person as an unwilling voyager who sets out to search for an unknown and inexplicable shore:

Now launch the small ship, now as the body dies
 and life departs, launch out, the fragile soul
 in the fragile ship of courage, the ark of faith... (Lawrence 1947, p. 149).

However, Lawrence's persona evokes the possibility of redemption from suffering by making appropriate preparations for the voyage and maintaining one's integrity in the face of the “dark flight down oblivion”:

O build your ship of death, your little ark
 and furnish it with food, with little cakes, and wine
 for the dark flight down oblivion (p. 139).

with its store of food and little cooking pans
 and change of clothes,
 upon the flood's black waste,
 upon the waters of the end
 upon the sea of death, where still we sail
 darkly, for we cannot steer, and have no port (p. 149)

According to Lawrence's *ars moriendi*, the suffering of dissolution and incipient oblivion can be alleviated by personal agency. By building a “ship of death” and stocking it with provisions we impose order on the experience and make it comprehensible.

The examples quoted suggest that sustained suffering may have two quite different outcomes. The sufferer either ends up in a “hard, stagnant painful torpor” with “my own will just a hollow joke,” or he or she transforms himself or herself into a “fragile ship of courage, the ark of faith.” Reich (1989) identifies three stages in the arc of suffering. These are not quantitative stages (i.e., each progressively worse), but rather temporal changes that occur as a person successfully confronts and overcomes suffering. According to Reich, when an individual experiences catastrophic illness or loss, he or she initially responds with silence, shock, and immobilization. The sufferer is struck dumb, unable to make informed decisions because loss overwhelms agency. Autonomy diminishes. Imagination implodes. Reich identifies this as *mute suffering*, or speechlessness in the face of catastrophe. Persons who never move beyond this state remain locked in a “hard, stagnant painful torpor.”

In the stage of *expressive suffering*, the sufferer seeks to understand the experience by finding a language in which to express it. Daudet accomplishes this in journal entries, while Akhmatova and Lawrence employ a structured literary approach. The literary control achieved in their poetry parallels an internal process of finding a voice to articulate and, thus, gain influence over, their suffering. This suggests a more universal process, documented in these cases by artistic creation, but available

to all sufferers through reflection and self-expression. For example, a patient with cancer may learn to express his or her deepest fears and sense of loss to family members, or to a chaplain or health professional, in a manner that encourages conversation. The expressive sufferer “speaks” in his or her own style, using personal resources and coping skills. In fact, expressive suffering always requires the participation of others, if only as listeners (Reich, pp. 86–91).

Akhmatova speaks directly to her suffering, “Do what you please, take any shape that comes to mind.” She announces this sentiment defiantly, the words of a tough woman who has survived decades of persecution. Daudet, on the other hand, describes his reaction to syphilitic pain with a finely wrought image: “the squeal of a woman before danger actually strikes.” He distances himself from the crisis by implying that his cries are premature, even though his pain is severe. In another part of “The Ship of Death,” Lawrence elsewhere a rotting fruit metaphor that acknowledges that he has dropped off the tree of life; his soul has fallen to the ground and begun to rot.

Reich calls his third and final stage *a new identity in suffering*. Here, the sufferer discovers a new self, or a new understanding of self. The old self may well have been beaten up beyond recognition, but in some important sense a resurrected self, or character, has emerged. The new self may manifest itself in outward activities, as, for example, Lawrence’s admonition to stock the ship of death “with food, with little cakes and wine,” but such pragmatic behaviors reflect a deeper personal transition (Reich 1989, pp. 86–91). In the next section, I discuss hope – specifically, deep hope – as the process by which one can forge a new identity in suffering.

In summary, existential suffering occurs when a person is threatened by, or experiences, the loss of identity, dignity, and/or life meaning. The initial response to this calamity is shock and silence (mute suffering), followed by attempts to understand and articulate the experience (expressive suffering). Such self-expression can itself be therapeutic, but the circumstances associated with severe illness often make reflection and conversation difficult (e.g., pain, isolation, anxiety, depression, low energy level, social, or cultural barriers). However, even in the face of incurable illness, amelioration of suffering is possible.

Suffering and Dignity

For many, an important component of suffering near the end of life is the perception that physical and mental deterioration result in the loss of dignity. They believe that the process of terminal illness is undignified in at least two ways. First, the suffering person may appear weak, vulnerable, even repulsive, to others. Dementia, delirium, incontinence, odors, enfeeblement: all of these seem inconsistent with human dignity. Second, progressive illness threatens, and often obliterates, autonomy, or self-determination. In our secular society, many consider moral agency (autonomy) to be the *sine qua non* of human dignity. Thus, diminished autonomy is equivalent to loss of dignity. Those who argue for the legalization of medically assisted death (physician-assisted suicide and euthanasia) argue that they are supporting “death with dignity.” *This phrase implies that lack of choice over when and how your death will occur (i.e. the “right to die”) means loss of dignity.*

The dignity-as-choice proposition discounts the relational and social dimensions of personhood. A dignified death in most cultures throughout most of human history was and is predicated on relationships between the individual and others. Dying must be viewed as both a personal challenge and a social role; in fact, these are two faces of the same process. For example, in traditional Chinese culture the dying patient suppresses self-efficacy in favor of family efficacy. She abdicates responsibility for decision making, while representative family members take charge of her final drama (Galanti 1997). It is considered rude and undignified even to mention death in the presence of the dying person, although the patient herself is well aware of the cultural liturgy in which she is playing a role. On the contrary, in American culture we focus the responsibility on the dying person himself

or herself, insisting on his or her choosing among the options for treatment, although we often mask the meaninglessness of the options we offer (Holstein 1997). A more robust concept of human dignity would place self-determination into a dynamic relationship with other important social values, as many religious and existential writers do in their reflections on dignity (Mendiola 1996).

Chochinov et al. (2002a) conducted a cross-sectional study of perceived dignity in 213 palliative care patients, all of whom had cancer and were expected to die within 6 months. The great majority of these patients indicated that they maintained a strong sense of personal dignity, with only 16 (7.5%) reporting that they experience “fractured” dignity. The authors concluded, “The finding suggests that a person’s sense of dignity is a particularly resilient construct and, in most instances, able to withstand the various physiological and psychological challenges that face patients who are terminally ill” (Chochinov et al. 2002a, p. 2028). Interestingly, “fractured” dignity was associated with hospitalization, but not with acuity of illness or proximity of death. These investigators have subsequently developed an empirical model for dignity at the end of life and devised a program of “dignity-conserving therapy” for palliative care patients (Chochinov et al. 2002b, 2005; Chochinov 2007). It is important not to generalize from the relative lack of dignity-loss in these studies because all patients were enrolled in palliative care settings, while only a small minority of Americans receives palliative care in the final months of their lives. They are much more likely to be subjected to fragmented and invasive care that may, in fact, contribute to the loss of dignity that many fear.

It appears that the excess suffering caused by loss of dignity at the end of life may be less common than those who fear it perceive to be the case. In most cases dignity seems to be resilient and able to reframe itself in a broader, more relational, context when faced with the “indignities” of terminal illness. In particular, the phrase “death with dignity” should not be trivialized as a euphemism for physician-assisted death.

Hope: An Antidote for Suffering

Medical Beliefs About Hope

As Claudio observes in *Measure for Measure*, “The miserable have no other medicine, but only hope” (Shakespeare 1952, p. 1116). Like Claudio, doctors have long looked upon hope as a universal balm. Thus, physicians have generally considered it their duty to assure that patients remained hopeful, even in the face of incurable disease or fatal injury (Groopman 2004). Promoting hopefulness usually involved manipulating the truth, or telling outright lies, about the patient’s condition. This practice was grounded in two assumptions. First, the empirical assumption that knowledge of a terminal condition would destroy the patient’s hope, and, second, the moral assumption that promotion of patient welfare trumps respect for patient self-determination (autonomy) in medical practice.

They argued that candor with terminally ill patients was usually unethical because “the most disastrous results may follow a tactless warning” (Hertzler 1940, p. 98). Physicians frequently shared anecdotes about patients who became hopeless, depressed, and suicidal upon learning their prognoses.

This attitude toward truthfulness has changed radically during the last 4 or 5 decades. In 1961, 90% of surveyed oncologists reported that they did not disclose cancer diagnoses to their patients (Oken 1961), but less than 2 decades later, 97% of physicians believed it was preferable to disclose a diagnosis of cancer (Novack et al. 1979). There are many reasons for this reversal of belief, some of them external to medicine, such as changes in social mores and patient expectations (Kodish and Post 1995). We now know that most people do, in fact, want to know the extent and prognosis of their disease. Moreover, experience in palliative medicine teaches us that it is often quite possible – even natural – for patients to remain deeply hopeful, even in the full awareness of impending death.

The development of palliative medicine as a medical specialty and the growth of hospice and palliative care services have led to a more scientific and humane approach to the suffering of terminal illness (Cherny 2004). Palliative care clinicians have reframed the traditional medical approach to hope in light of two important realizations. First, the goals of therapeutic hope need not involve disease remission or cure, or even prolongation of life, but rather they may include smaller, more focused objectives, such as resolution of family conflict or a picnic with friends at a cherished place. Thomas Warr writes, “As active treatment fails, hope can take on another form. Hope is that the remaining days of life will be happy ones that tasks at the end of life can be addressed, relationships mended and finalized, and every moment treasured” (Warr 1999). In other words, hope for a cure may transmute into hope for more realistic objectives. As one approaches death, hope endures, but with new aspirations. The physician’s role in this process is “setting goals to maintain hope” (Von Roenn and von Gunten 2003).

In their article entitled, “Hope for the best, and prepare for the worst,” Beck et al. (2003) provide us with a useful way of analyzing this situation. They argue that terminally ill patients often exist in a state of “middle knowledge,” in which they alternate between planning for continued life and preparing for death (Weisman 1972, McCormick and Conley 1995). The dynamic between these poles allows physicians to encourage the dual agendas of hoping for the best (gently supporting a milieu of hopefulness) and, at the same time, doing the work of preparation (providing information, addressing fears, encouraging relationships). In this framework the patient does, in fact, prepare for death, while also maintaining hope.

The second realization of palliative care clinicians is that hope is much more resilient than physicians once thought. Hope can bounce back in the face of bad news and disappointment, even repeated disappointment. In fact, there appears to be a form of hope that underlies “hoping for” specific goals and that persists even after seemingly attainable objectives (e.g., a granddaughter’s graduation, the enjoyment of a hamburger, a pain-free day) become unlikely. Many commentators have identified this phenomenon and suggested various names for it. I will discuss this form of “hoping against hope” in the next section, but first must differentiate it from what physicians commonly refer to as *false hope*.

False Hope

Palliative care physicians speak of false hope or the “dark side of hope” in cases where a patient’s treatment goals are unrealistic and his or her embrace of those goals leads to additional suffering to himself or herself and his or her family. For example, a patient with terminal pancreatic cancer might choose to undergo repeated courses of aggressive chemotherapy that cause him or her violent side effects, rather than choosing a palliative regimen that could minimize symptoms and maximize quality of life. Moreover, this patient’s seemingly hopeful choices might put his or her family under severe psychological and financial stress. Although real hope is therapeutic, physicians argue, false hope is damaging (Snyder et al. 2002). But what, precisely, is the distinction?

In some cases the distinction might turn on the characteristics of the physician–patient–family relationship than on the extravagance of the hope. Is the patient interesting and pleasant, or demanding and manipulative? Is the family supportive or disruptive? Are clinical interactions fraught with tension or confrontation? Helwick quotes with approval one clinician’s description of a terminal leukemia patient’s “endless hope”: “He had a tremendous amount of optimism... and he inspired the oncology team” (Helwick 2010). In this case the physician saw himself as an advocate for the patient, a character in his story, and affirmed his endless hope. However, when a patient is less inspiring and more disruptive, or causes pain in those around him, endless hope may morph into false hope. In other cases false hope might actually be generated by the physician, the result of miscalculation,

over-optimistic promises, and manipulation of information about the prognosis or treatment. In other words, physicians may be responsible for false hope by acting under the guise of “therapeutic privilege” (Pellegrino and Thomasma 1996).

Perhaps the best conceptual way of approaching false hope is via Beck, Quill, and Arnold’s framework of “hoping for the best, preparing for the worst” (Beck et al. 2003). In this context, the hope part of the equation need not be scaled down or realistic. Why not hope for a miracle cure? Why not have endless hope? The impression of “falseness” arises only when the patient’s hope is unassociated with the mind-set of, and activities involved in, preparing for the worst.

Deep Hope: The Song Without Words

Dickinson (1960), a poet whose life was chock full of frustrated goals, wrote several poems about hope. This one is perhaps the most well-known:

“Hope” is the thing with feathers—
That perches in the soul—
And sings the tune without the words—
And never stops—at all—

And sweetest—in the Gale—is heard—
And sore must be the storm—
That could abash the little Bird
That kept so many warm—

I’ve heard it in the chilliest land—
And on the strangest sea—
Yet, never in Extremity,
it asked a crumb—of Me (p. 116).

Dickinson’s observations that hope has “kept so many warm” and is “sweetest” during the worst of times coincide with traditional medical beliefs. She also highlights hope’s endurance: a bird that “perches in the soul” and continues singing, despite the storms and extremities of life. Hope never asks for payment in return for its faithful service. However, the bird metaphor suggests another insight about hope: its sweet song is wordless, a melody without lyrics. What can this mean? Is the Amherst poet implying that the cognitive content of hope (i.e. the object hoped for) is not essential? Indeed, she seems to suggest a natural outpouring of song (hopefulness) that underlies whatever words we may attach to it. In a letter to his friend Joseph Goodman, Samuel Clemens offered a different image from nature to capture the ubiquity and naturalness of hope: “God save us,” he wrote, “... from a hope-tree that has lost its faculty for putting out blossoms” (Ober 2003).

The existentialist philosopher Gabriel Marcel distinguished between two different forms of hope as expressed in the statements, “I hope...” and “I hope that...” (Marcel 1960). The latter corresponds to the usual understanding of hope as having a specific goal, whether superficial (“I hope that it doesn’t rain tomorrow”) or profound (“I hope that the bone marrow transplant will cure my leukemia”). However, the former statement “I hope...” is “a more general cosmic conviction affirming human life or being in general. This is the hope about the meaningfulness and purpose of human existence” (Pellegrino and Thomasma 1996, p. 57).

Pellegrino and Thomasma use the term *transcendental hope* for Marcel’s second, deeper form of hope and they relate it closely to religious, specifically Christian, belief (Pellegrino and Thomasma 1996, p. 64). However, it is unnecessary to postulate transcendence or religious dogma to maintain a conviction that one’s life has meaning and purpose, even in the face of imminent dissolution. Viktor Frankl provides an example of an immanent, psychological formulation. In *Man’s Search for Meaning*, he directly confronts the problem of suffering. We experience suffering when illness or

catastrophe threatens our integrity. We encounter our own vulnerability to destruction, the negation of everything that is meaningful to us. Yet, suffering also provides us with a profound opportunity to *discover meaning* in our lives. For Frankl, Thomasma and Pellegrino's *transcendent hope* might be recast as *having-agency-to-discover-meaning*.

The clinical literature includes a number of attempts to capture the distinction between hoping-for a specific outcome and a deeper, more existential form of hope. Like Frankl, Miller characterized the deepest level of hope as the experience of finding meaning in loss or suffering (Miller 1985). DuFault and Martocchio (1985) contrasted *particularized hope*, which is related to specific desired objectives, to *generalized hope*, which is the "intangible inner experience of hope." In a longitudinal study of 30 dying patients, Herth (1990) defined deep hope as an "inner power directed toward enrichment of being." In a study of 11 palliative care patients in Sweden, Benzein et al. (2001) described their reports of experiencing tension between the two states of "hoping for something" and "living in hope." All these dichotomies appear to express the same notion: the existence of a level of hopefulness that underlies and sustains hoping-for-a-specific-future-goal. I call this *deep hope*.

Between Clinician and Patient

Physicians and other clinicians who treat seriously ill patients aim to relieve suffering by curative or remissive measures, i.e., directed toward curing or diminishing the disease process; and palliative measures, i.e., directed toward relieving symptoms and enhancing quality of life. Yet suffering may, and often does, elude these medically oriented approaches because they fail to address the existential core of suffering. Deep hope serves to ameliorate suffering, but clinicians may not understand how to facilitate their patients' hope, or enhance their patients' dignity, or even encourage them to express their suffering, beyond giving appropriate disease-specific diagnosis and treatment.

Several investigators have examined personal and clinical correlates of deep hope. Herth (1990), who, as noted earlier, defined deep hope as an "inner power directed toward enrichment of being," studied palliative care patients and identified seven "hope fostering" characteristics: interpersonal connectedness, attainable goals, spiritual base, personal attributes, lightheartedness, uplifting memories, and affirmation of worth. As the patients moved closer to dying, several of these dropped out, but interpersonal connectedness, spiritual base, and attainable aims remained significant. Herth also noted three "hope-hindering" characteristics: uncontrollable pain, abandonment–isolation, and devaluation of personhood.

In a later study of 32 oncology patients, Post-White et al. (1996) identified similar clusters of hope-enhancing and hope-hindering features. Among hope-enhancing strategies, they listed finding meaning, affirming relationships, and "living in the present." Benzein and Savemen (1998) discovered that patient hope was positively correlated with good nurse–patient relationships. Herth (1993) also studied geriatric persons living in institutions and in community settings. She found several hope-enhancing features were similar to those in her earlier investigation (interpersonal connectedness, spiritual base, lightheartedness, uplifting memories, and attainable goals), but, aside from uncontrolled pain, hope-hindering factors were different: hopelessness in others, depleted energy, and impaired cognition (Herth and Cutcliffe 2002).

These studies are, of course, only suggestive, and the noted correlations do not necessarily imply causal relationships. However, it is interesting that a large number of the identified factors can be influenced, either positively or negatively, by physicians and other healthcare professionals. Obviously, medical treatment can control pain. The clinician–patient relationship can help prevent abandonment and isolation, affirm worth, ensure respect for the suffering person, foster connectedness, suggest attainable goals, and, where appropriate, facilitate lightheartedness. This cluster of factors intimates that clinicians can relieve suffering by fostering deep hope.

To achieve this goal it is necessary: (a) to avoid the trap of detached concern, (b) to develop and practice the skills of clinical empathy, (c) to understand the power of compassion, and (d) to develop the bond of compassionate solidarity.

Detached Concern

Contemporary medical beliefs throw up a roadblock when it comes to understanding and treating suffering. Medical educators typically recommend emotional detachment or *detached concern* as the clinician's proper stance toward suffering patients. In the last 50 years, detached concern has evolved from a simple descriptive term used by medical sociologists recording their observations of medical students (Lief and Fox 1963; Becker et al. 1961) to a prescriptive or normative concept that identifies the *proper* attitude of doctors toward their patients. As part of this process, educators linked detached concern with William Osler's famous medical virtue, *aequanimitas*. In his essay of that name, Osler (2001) warned medical students that "a calm equanimity is the desirable attitude" and encouraged them to develop "such a judicious measure of obtuseness as will enable you to meet the exigencies of practice with firmness and courage." Late twentieth century medical education co-opted these sentiments and identified them with detached concern.

Educators give two reasons for the belief that professionalism demands substantial emotional and psychological distance between physician and patient. First, detachment protects the physician from being overwhelmed and paralyzed by pain and suffering. Second, detachment protects the patient. Medical decisions ought to be objective, uninfluenced by feelings and biases. Blumgart, for example, wrote that detachment is necessary to prevent "loss of objectivity and perspective" (Blumgart 1964). Thus, an emotional connection with the patient may bias clinical judgment and compromise patient care.

Such beliefs both reflect and support today's prevalent model of disease and medical intervention, in which disease can, in principle, be completely understood in anatomical, physiological, biochemical, or even molecular terms. The suffering that results from disease or trauma is considered an epiphenomenon, expected to resolve when the condition is cured, alleviated, or controlled. This version of the biomedical framework limits the scope of medical concern to aspects of suffering considered "fixable" (Gunderman 2002). It also implies that the catastrophic effect of illness on conceptions of personhood and self-worth is somehow mistaken or illegitimate; if an existential crisis occurs, it is not a problem to be addressed by medicine. As theologian Stanley Hauerwas writes, "The ideology... institutionalized in modern medicine requires that we interpret all illness as pointless" (1990, p. 69).

So much for the detachment part of detached concern. The "concern" component is intended to express the residual commitment that physicians should have to their patients, given their professional detachment. Concern is a weaker and more ambiguous word than "care" or "compassion." In other contexts the statement, "I am concerned about you" is open to both positive (looking out for his or her welfare) or negative (questioning his or her behavior) interpretations. In either case the phrase is cautious and less open-ended than the alternate sentiment, "I care for you," which seemingly violates the professional requirement for detachment. Detached concern opens medicine to Cynthia Ozick's indictment in "Metaphor and Memory"; physicians cultivate detachment from their patients because they are afraid of finding themselves "too frail ... to enter into psychological twinship with the even frailer souls of the sick" (Ozick 1989).

Surprisingly, despite their profession's orthodox model of detached concern, physicians almost universally agree that *relationships* are significant in medical practice. Most physicians also assert that they practice the "art of medicine," which is far more than the sum of medicine's biological sciences. This "art," they contend, includes, among other components, compassion, responsiveness, clinical judgment, advocacy, rapport, and bedside manner. In other words, the majority of physicians

seem simultaneously to hold (and compartmentalize) two conflicting beliefs: doctors should be detached and doctors should be connected.

Clinical Empathy

Empathy is a hard nut to crack because it challenges the conventional medical opinion that thinking is thinking, and feeling is feeling, and never the twain shall meet. *Clinical empathy is the ability to understand the patient's situation, perspective, and feelings, and to communicate that understanding to the patient.*

This definition has three important implications. First, empathy has a cognitive focus. The clinician enters into the perspective and experience of the other individual by means of verbal and nonverbal cues, but does not in the process lose her own perspective. Hojat emphasizes this cognitive aspect in his *Empathy in Patient Care*, a comprehensive survey of clinical empathy, including its history, development, scope, methodologies, and results of empirical studies (Hojat 2009; Hojat et al. 2002). Second, empathy also has an affective or emotional focus. To “know” emotions we have to feel them. Jodi Halpern uses the term *resonance emotions* to describe these feelings generated in the clinician as she practices empathy (Halpern 1992, 2007). She writes, “The special professional skill of clinical empathy is distinguished by the use of this subjective, experiential input for specific, cognitive aims. Empathy has as its goal imagining how it feels to be in another person’s situation” (Halpern 2003). Psychiatrist Robert Coles uses the term *moral imagination* to designate this capacity for empathic understanding (Coles 1989).

Finally, the definition requires that clinical empathy has an action component. The practitioner communicates understanding by checking-back with the patient, using, for example, statements like “let me see if I have this right” or “I want to be sure I understand what you mean” (Coulehan et al. 2001). Thus, clinical empathy is a positive feedback loop in which the physician titrates his or her understanding by checking back with the patient in an iterative process. This gives the patient opportunities to correct or modulate the physician’s formulation. At the same time it expresses the physician’s desire to listen deeply, thereby reinforcing a bond or connection between clinician and patient (Coulehan and Block 2006).

In Howard Spiro’s essay “What is empathy and can it be taught?,” he answers the second question with a qualified yes, noting that “a better question might be, ‘Can we recover the empathy we once had?’” (Spiro 1992). Arguing that the process of medical education tends to diminish our openness to others’ feelings and experience, Spiro believes that enhancing clinical empathy is more of a restoration project, rather than a pedagogical one. Perhaps he overstates the case, but it is clear that medical education tends to narrowly focus students’ attention on patients-as-objects, thus down-regulating their receptors for experiencing patients-as-subjects. In particular, concepts such as detachment and detached concern create barriers to the development of clinical empathy.

From Empathy to Compassion

The words “patient,” “patience,” and “compassion” derive from the Latin stem *pass-*, “to suffer.” Patience refers to the calm endurance of inconvenience, pain, or suffering. A patient is a person who endures suffering. Compassion means to suffer with. To claim that compassion is a medical virtue is to assert that doctors ought to *suffer with* their patients. This is a far cry from detached concern.

Compassion is impossible without empathy, because only through empathic understanding can we recognize other persons as subjects like ourselves. Experiencing another person’s suffering by

means of empathy, resonance emotions, and the moral imagination creates an experiential bond quite different from the attitude of pity, which carries the connotation of separateness and condescension. Pity is often associated with detached concern; after all, who would not be moved to pity by the unfortunate cases physicians encounter? In fact, the word “unfortunate” is often used in medicine as a code word to indicate patients who are deserving of pity, as in the following: “This unfortunate 47-year-old man with anaplastic adenocarcinoma of unknown origin...” Or, “This unfortunate 16-year-old girl with Down syndrome and acute leukemia...” In such cases, the speaker indicates to his or her colleagues that it is appropriate for them to look with pity upon the patient.

Warren Reich defines compassion as “the virtue by which we have a sympathetic consciousness of sharing the distress or suffering of another person and on that basis are inclined to offer assistance in alleviating and/or living through that suffering” (Reich 1989, p. 85). Leonard Blum offers a second, synergistic definition: compassion is “a complex emotional attitude toward another, characteristically involving imaginative dwelling on the condition of the other person, an active regard for his or her good, a view of him or her as a fellow human being, and emotional responses of a certain degree of intensity” (Blum 1980, p. 509). It is clear from these definitions that compassion involves (a) a sympathetic awareness of the others’ distress, (b) a sense of sharing that distress in some manner; and (c) an inclination to offer assistance. Writing specifically about medicine, Sulmasy contends that a compassionate physician addresses his or her patient’s suffering at three levels: (a) the objective level, by recognizing suffering, (b) the subjective level, by internally responding to the suffering, and (c) the operative level, by performing concrete healing actions (Sulmasy 1997, p. 103).

Sulmasy’s objective level may at first suggest the same concept of objectivity so highly valued in detached concern. However, in the case of compassion, the observing instrument (i.e. the physician) is sensitive to a wider spectrum of data. By practicing clinical empathy, he or she identifies the character and magnitude of suffering, in addition to symptoms and signs of disease processes. Self-awareness is a prerequisite for Sulmasy’s subjective or internal response to suffering. Many commentators stress the need for physicians to better understand their own beliefs, feelings, attitudes, and response patterns (Kearney et al. 2009; Meier et al. 2001; Novack et al. 1997; Coulehan and Williams 2003; Frankel et al. 2003). Today’s narrative medicine movement responds to this need by teaching self-awareness, clinical empathy, and reflective practice (Charon 2001a, b, 2004; DasGupta and Charon 2004; Morris 2001; Bolton 1999; Coulehan 2005). Students enhance their repertoire of life experience through narratives of illness and patient care, and enhance their professional identities by reflecting upon, and writing about, their clinical experiences (Coulehan and Clary 2005; DasGupta and Charon 2004). Sulmasy’s third level of compassionate response, concrete healing acts, takes place in the context of compassionate solidarity with the patient.

Compassionate Solidarity

The objective and subjective components of compassion find their fulfillment in action directed toward alleviating suffering. This action, of course, includes efforts to cure the disease and suppress the symptoms. However, the creation of an empathic connection is in itself a healing action. Being present to, listening, affirming, and witnessing are actions that help relieve the patient’s suffering by demonstrating respect and facilitating deep hope (Coulehan 2011). I call this type of therapeutic relationship *compassionate solidarity*. Unlike detached concern, its focus is on the patient as a person, rather than on the disease.

In his *Autobiography* (1951, p. 356), the American physician–poet William Carlos Williams wrote that he often began his evening office hours feeling totally exhausted, but as soon as he began seeing his patients, “I lost myself in the very properties of their minds: for the moment at least I actually became them, whoever they should be, so that when I detached myself from them... it was

as though I were awakening from a sleep.” Williams (1951) describes a state of immersion in which the “I” perspective remains intact (e.g., “in a flash the details of the case would begin to formulate themselves into a recognizable outline”), but stays in the background. He is entirely present to the situation, thus bridging the gap between subject and object. Nouwen et al. (1982) capture this sense of immersion in their statement, “Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion in the condition of being human.”

Summary and Conclusion

Suffering is the experience of distress or disharmony caused by the loss, or threatened loss, of what we most cherish. Suffering involves dissolution, alienation, loss of personal identity, and/or a sense of meaninglessness. It results from the stripping away of beliefs and symbols by which we construct a meaningful narrative of human life in general and our own lives in particular. Suffering is often compounded by a sense of threatened or lost dignity.

Hopelessness is an extreme manifestation of suffering. However, hope is a natural human resource that can palliate and contribute to healing. Hope is also more flexible and resilient than physicians, who traditionally withheld or manipulated the truth about dire prognoses, believed it to be. Maintaining hope, especially deep hope, is an antidote to suffering.

The vocation of physicians and other health professionals is, insofar as possible, to relieve suffering caused by illness, trauma, and bodily degeneration. However, since suffering is an existential state that may not parallel physical or emotional states, health professionals cannot rely solely on knowledge and skills that address physiological dysfunction to be effective at relieving suffering. Rather, clinicians must learn to engage the patient at an existential level and to engender hope.

For several decades detached concern has been the standard approach to patients taught by medical educators. This term was initially employed by sociologists to characterize students’ and physicians’ observed detachment and their inclination to treat patients as objects, rather than as subjects of experience. Later, medical educators adopted detached concern as a normative relationship, because they believed it promoted objectivity and protected the physician’s emotional resources, while acknowledging medicine’s beneficent motivation (concern). However, in reality, contemporary medical education and practice favor a process of progressive detachment from patients that devalues subjectivity, emotion, solidarity, and relationship as irrelevant and harmful. Such an ideal – fortunately not achieved by most clinicians – almost ensures that practitioners lose the ability to fully appreciate and respond to human suffering, or to facilitate hope. The term *compassionate solidarity* summarizes an alternate model of the physician–patient relationship. Compassionate solidarity begins with empathic listening and responding, which facilitate objective assessment of the others’ subjective state; requires the physician to develop reflectivity and self-understanding; and is in itself a healing, hope-promoting act.

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