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COMPASSIONATE SOLIDARITY

suffering, poetry, and medicine

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ABSTRACT Suffering is the experience of distress or disharmony caused by the loss, or threatened loss, of what we most cherish. Such losses may strip away the beliefs by which we construct a meaningful narrative of human life in general and our own in particular. The vocation of physicians and other health professionals is to relieve suffering caused by illness, trauma, and bodily degeneration. However, since suffering is an existential state that does not necessarily parallel physical or emotional states, physicians cannot rely solely on knowledge and skills that address physiological dysfunction. Rather, they must learn to engage the patient at an existential level. Unfortunately, however, medical pedagogy encourages “detached concern,” which devalues subjectivity, emotion, relationship, and solidarity. The term “compassionate solidarity” summarizes an alternative model, which begins with empathic listening and responding, requires reflectivity and self-understanding, and is in itself a healing act. Poetry, along with other imaginative writing, may help physicians and other health professionals grow in self-awareness and gain deeper understanding of suffering, empathy, compassion, and symbolic healing.

IN MEDICINE THE WORDS *pain* and *suffering* are so frequently in tandem that for many physicians pain-and-suffering glides off the tongue as a single concept. Suffering tends to be treated as merely the psychological or personal dimension of pain. It follows, then, that since pain and other unpleasant symptoms *cause* the suffering, this negative psychological reaction should be eliminated by treating pain or, better yet, by curing the disease. Thus, the primary focus of research and teaching about pain-and-suffering is on nociceptors and pharmacology.

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However, physicians who maintain this professional belief system about suffering are not necessarily insensitive to the existential or spiritual dimension of suffering. They merely separate their concept of an appropriate professional response to suffering in patients from their beliefs about suffering that touches them personally.

More than a quarter of a century ago, Eric Cassell (1982) argued that physicians do, in fact, have a professional responsibility to understand and treat suffering at an existential level, especially in the care of seriously ill and dying patients. In a famous *New England Journal* article, "The Nature of Suffering and the Goals of Medicine," and later in his book of the same title, Cassell defined suffering 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" (p. 639). This definition identifies an end state ("severe distress"), operative conditions ("loss" or "threat of loss"), and substantive qualities ("integrity, intactness, cohesiveness, or wholeness"). Michael Kearney (1996), an Irish psychiatrist and hospice physician, provided a synergistic definition of "soul pain" (his term for suffering) as "the experience of an individual who has become disconnected and alienated from the deepest and most fundamental aspects of him or herself" (p. 60). The psychiatrist Victor Frankl (1997) specified these "deepest and most fundamental aspects" as the matrix of beliefs and expectations that give meaning to life. Hence, he asserted that: "Man is not destroyed by suffering, he is destroyed by suffering without meaning" (Swenson 2005, p. 52).

These two opposing views—that physicians should address suffering only indirectly by treating disease, and that physicians should get close enough to patients to understand their existential suffering—reflect different radically beliefs about the nature and mechanisms of healing. Nonetheless, most physicians incorporate elements of both sets of beliefs in their professional lives, although they often do not appreciate the resultant incompatibility. In this article I explore these different therapeutic responses to suffering. First, I look more carefully at the experience of suffering as expressed by creative writers and present a patient case history that illustrates the central role of symbols in healing. In the following sections, I analyze the doctrine of objectivity and detachment in medicine, and the doctrine of compassionate solidarity, which preserves a form of objectivity while promoting the formation of empathic relationships with patients. Through compassionate solidarity physicians may become healers as well as treaters. Finally, I argue that poetry (and other creative writing) is a useful adjunct for helping physicians to understand suffering, solidarity, and healing, and also for developing the self-awareness needed to become effective healers.

THE EXPERIENCE OF SUFFERING

Suffering as Disharmony

Sarah Mailcarrier was an elderly Navajo woman who lived at Cornfields on the Navajo Reservation. The dirt road to Cornfields ended at a trading post in a clump of cottonwood trees along a dry arroyo in Beautiful Valley. Rugged tracks led from the trading post to scattered camps in the surrounding desert. At the time I was a Public Health Service physician at Greasewood Clinic, about 20 miles south of Cornfields, Mailcarrier was the matriarch of a camp with five or six homes where her daughters and their families lived. A daughter had asked me to come and see her because of pain and swelling in her legs. When I examined Mailcarrier, who was lying on a mat in her *hogan*, cachectic and groaning in pain, I was sure she was terminally ill.

Our clinic driver took Mailcarrier to Fort Defiance Hospital, some 50 miles east of Cornfields. Sure enough, she suffered from cancer of the cervix that had spread throughout her pelvis and abdomen, blocking lymphatic ducts and causing massive edema. The cancer was also threatening her kidneys, her ureters already partially obstructed. The only available treatment was radiation, which might shrink the tumor and extend the patient's life. But radiation therapy wasn't available at the small reservation hospital, so she would have to travel another 40 miles to a larger regional hospital in Gallup, New Mexico.

In fact, the patient and her family declined further medical intervention. Rather, they carried her home in the bed of a pickup truck, never stopping at the hospital pharmacy to fill her morphine prescription. The family then hired a medicine man or *ha'atali* to conduct a Blessingway, a nine-day healing ceremony, in their camp later that month. The Blessingway was a major event that attracted relatives and friends from settlements over the mesa and down the valley. In addition to ritual chants, dances, and sand paintings, participants enjoyed several evenings of feasting and socializing. The ceremony was expensive. Mailcarrier's family had to slaughter quite a few sheep, in addition to raising money to pay the *ha'atali* and his assistants. Fortunately, however, the Blessingway was a great success. Mailcarrier's pain disappeared, her energy increased, and she was able to continue in her role as family matriarch for several months. When I visited her, she appeared serene. Eventually, she drifted into a coma and died.

When I first met Sarah Mailcarrier, she was suffering terribly. I could see it in her face and eyes, as well as in those of her children. Her groans were unmoored and disoriented. They were soul-groans. We usually translate the Navajo term for suffering as "disharmony," meaning that the sufferer has lost his or her way; more generally, the Navajo Way, which gives structure and meaning to Navajo life. As an Anglo doctor, I couldn't do anything to address this existential problem, which had been precipitated by her illness. However, the traditional healing ceremony could and did relieve her suffering. During the final months, when I vis-

ited her frequently, Mailcarrier didn't seem to suffer, even though she must have had severe symptoms from her cancer. It seems paradoxical that while her cancer got worse, her suffering diminished.

Sarah Mailcarrier's successful treatment neither extended her life nor cured her cancer. Her world had been knocked off kilter by a radical threat to her internal harmony. By manipulating meaningful symbols and narratives, the *ha'atali* helped her to restore that harmony and alleviate her suffering. In some ways we may be less surprised that a Navajo woman "got better" from symbolic healing than we would be at the same response in a middle-class Anglo. Westerners have little trouble accepting that traditional healing practices can be effective in non-Western cultures (Morris 1998). However, it is more difficult for us to appreciate the same dynamics taking place in Western culture: that the patient's beliefs about the meaning of illness and his or her interaction with the healer influence whether—and how much—the patient suffers.

The other important lesson from Mailcarrier's Blessingway ceremony is that traditional Navajo medicine consists primarily of poetry (spoken, chanted, and danced to), in association with other artistic practices, like sandpainting and storytelling. In Western medicine we speak of the art of healing as one aspect or dimension of scientific practice. In Navajo culture, however, medicine is literally and quite obviously an art form (Coulehan 1992a). Thus, the Navajo case serves to introduce the concept that poetry provides us with deep insight into both the experience and the relief of suffering (Coulehan and Clary 2005).

Creative Expression of Suffering

The late 19th-century French novelist and playwright Alphonse Daudet wrote a series of notes about his experience of *tabes dorsalis*, a form of tertiary syphilis. These notes were recently translated and published by Julian Barnes as a collection called *In the Land of Pain* (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)

Daudet illustrates three aspects or stages of suffering: the cry for help, the desire to flee, and, finally, the indifference and immobilization. Anna Akhmatova, the

great 20th-century Russian poet, spent most of her life laboring under official Soviet disapproval. Her husband was killed, her son imprisoned, and she endured a marginal hand-to-mouth existence for decades, her poems suppressed by the government. After her son Lev was arrested in 1938, Akhmatova waited every week in line at the prison gates for 17 months, hoping that she would be allowed to give him some food or warm clothes. Dozens, perhaps hundreds, of other women waited with her, hoping for word of their husbands, sons, or fathers. Akhmatova later wrote “Requiem” to express her suffering during that period:

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. (VII, p. 139)

.....
 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. (VIII, p. 139)

.....
 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. (IX, p. 140)

In this case, the first excerpt communicates the poet’s recognition that she must change her life in response to suffering. She must act—smash her memories, turn her heart, relearn how to live—rather than remain passive. In the next segment, however, the poet has become passive and cynical. Finally, she appears to welcome annihilation. Her numbness is transformed into a strong, but confrontational, desire for nothingness.

As poet and novelist D. H. Lawrence was dying of tuberculosis in late 1929 and early 1930, he wrote “The Ship of Death” and a number of related poems (Lawrence 1989). “The Ship of Death” is an explicit articulation of suffering, unified by two major metaphors, the body as a piece of decaying fruit and a ship setting out on the sea. For Lawrence the process of creating these works, which he drafted again and again, was a form of *ars moriendi*, a poet’s way of coming to terms with his inevitable dissolution:

Now it is autumn and the falling fruit
 and the long journey towards oblivion. (I, ll. 1–2)
 Already our bodies are fallen, bruised, badly bruised,
 already our souls are oozing through the exit
 of the cruel bruise. (V, ll. 32–34)

We encounter a grove of fruit trees in autumn. Overripe fruit has already fallen. Vital juices ooze into the ground. Our souls leak from wounds in our damaged bodies. The souls are frightened by the cold, uncertain world they encounter as they leave the body:

We are dying, we are dying, piecemeal our bodies are dying
and our strength leaves us,
and our soul covers naked in the dark rain over the flood,
cowering in the last branches of the tree of our life. (VI, ll. 46–49)

Lawrence's second metaphor imagines death as a voyage to an unknown and inexplicable shore. Human beings can "redeem" themselves from suffering by maintaining their 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. (V, ll. 38–40)
.....
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
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. (VII, ll. 56–64)

One may overcome suffering by building a "ship of death," thus imposing order on the experience and making it comprehensible, and by supplying food and small cakes, which is to say, by incorporating one's own death into a meaningful belief system.

It is instructive to consider these literary excerpts in the light of the three phases of suffering described by Warren Reich (1989). When a person is first confronted by catastrophic illness or loss, he or she responds with silence and immobilization. The sufferer is not only struck dumb, but he or she cannot make informed decisions—or sometimes any decisions at all—because the sense of loss overwhelms agency. Autonomy is diminished, and imagination gives out; it is not up to the task of creating meaningful images. Reich calls this stage "mute suffering," the experience of being speechless in the face of one's own suffering. Obviously, mute sufferers are unable to express their experience in poetry, prose, visual arts, or any form of imaginative communication.

"Expressive suffering" is the second phase, in which the sufferer seeks to understand the experience by finding a language to express it. Daudet does this by

writing personal journal entries, while Akhmatova and Lawrence go through the more structured process of creating poems that are intended to communicate with a larger audience. This poetic process parallels the sufferer's internal process of finding an expressive voice, which in itself can exercise some control over suffering. For example, the cancer patient may learn to articulate her deepest fears and sense of loss to family members, or to a chaplain or health professional, in a way that encourages conversation. The expressive sufferer can also respond in his own style, using his own habits of coping. Akhmatova chooses to speak to her suffering, "Do what you please, take any shape that comes to mind." In context, these sentiment are not submissive. They are spoken with attitude—Akhmatova was a tough woman who survived decades of persecution. Daudet, on the other hand, describes his reaction to syphilitic pain by creating a finely wrought image: "the squeal of a woman before danger actually strikes." In this he distances himself from dissolution by implying that his cries are premature, even though his actual pain is severe. Lawrence's rotting fruit metaphor acknowledges that he is now cut off from the tree of life. His soul has begun to disperse ("oozing through the exit / of the cruel bruise"), but finds itself terrified and presumably trying to reenter the world of the living ("cowers naked . . . in the last branches of the tree of life").

Reich's third and final phase is called "new identity in suffering," where the sufferer discovers a new self, or a new understanding of self, that in essence overcomes suffering by preserving personal integrity. The old self may have been destroyed, but a new self, a new character, has emerged. According to Reich, this process requires solidarity with others. In fact, even the second stage, expressive suffering, requires the participation of others, if only as listeners. Gregory Orr's poem "Tin Cup" illustrates the adoption of a new identity in suffering:

Here's a tin cup
furred with rust.
Here's a bad heart
I've lugged this far.

Begging? No.
Hauling with me
all a mortal has.

You think I'm grim
and thin, wizened
as a dry stick.
You think I've come
to bore you
with a long story
of torment.

And yet I swear
 I love this earth
 that scars and scalds,
 that burns my feet.

And even hell is holy. (Orr 2002, p. 9)

DETACHMENT: KEEPING SUFFERING AT ARM'S LENGTH

What is the physician's appropriate response to a patient's experience of suffering? What professional stance should be adopted when confronted by the suffering of seriously ill and dying patients? More concisely, is there a type of professional response that in itself tends to relieve suffering (in other words, is therapeutic)? Medical philosophy and practice provide us with at least two conflicting answers to these questions. The most widely accepted and institutionalized answer is that medical professionals should respond to suffering with objectivity and detachment (Bloom 1989; Hafferty and Franks 1994; Inui 2003; Lief and Fox 1963; Manson 1994; Zoloth-Dorfman and Rubin 1995). The other answer tends to be less well articulated, but is nonetheless highly valued by many practitioners: physicians should respond to their patients' suffering by forming bonds of compassionate solidarity with them (Bennett 2001; Charon 2001; Coulehan 1995, 2002; Farber, Novack, and O'Brien 1997; Novack et al. 1997).

Detached Concern

In both theory and practice, modern medicine focuses primarily on detachment as the proper response to suffering. The terms "clinical distance" and "detached concern" are also used, especially the latter. "Detached concern" is of particular interest, because it has evolved over the last 50 years from being a non-value-laden descriptive term to being a highly valued prescriptive term. Medical sociologists created "detached concern" in the 1950s to describe the sense of detachment they had observed in their studies of medical students and patients (Becker et al. 1961; Lief and Fox 1963). Later, medical philosophers and educators seized upon the term, endowing it with orthodoxy: medical students and young doctors were right to demonstrate emotional detachment from their patients (Petersdorf 1992). They identified two reasons for this. First, detachment protects the physician from being overwhelmed and paralyzed by pain and suffering. The layperson who faints at the sight of blood may, with proper training, become an accomplished surgeon, at least in part by learning to disconnect from the emotional side of the experience. The process of disconnecting begins with human dissection in the gross anatomy laboratory and develops over many years as the trainee is socialized into the culture of medicine. According to these beliefs, doctors who stay "soft" tend to get depressed and burn out.

The second reason for detachment is to protect the patient. Medical decisions ought not to be influenced by feelings and biases. Blumgart (1964), for example,

writes that detachment is necessary to prevent “loss of objectivity and perspective.” An emotional response may lead to biases in clinical judgment that compromise patient care; hence, the tradition that physicians ought not treat their loved ones. Emotional vulnerability impairs medical performance, and strong attachment (or repulsion) greatly impairs doctoring. To this way of thinking, even the doctor’s day-to-day emotional life (disregarding relationships with patients) should be looked upon skeptically, because emotions are intrinsically irrational and, at least to some extent, compromise the ideal of objectivity.

There is no empirical support for these claims, but they are widely accepted because they reflect today’s prevalent model of disease and medical intervention. In this model, disease is considered an insult or process that disrupts the body and can, in principle, be completely understood in anatomical, physiological, biochemical, or even molecular terms. Existential and spiritual suffering that results from disease (or trauma) is expected to resolve when the disease is cured, alleviated, or controlled. If a physician restores the patient to a satisfactory level of physical and emotional functioning, the patient’s suffering diminishes. If restoration is not possible, then medicine can’t address the suffering.

Detachment Is Not Enough

One important result of these ideas is that they limit the scope of medical concern to those aspects of suffering considered “fixable” (Gunderman 2002). They also imply that, from a human perspective at least, disease is—or ought to be—meaningless. Disease equals invasion, error, decay, and chaos; the doctor’s role is to fix these problems. But ideally they are problems without intrinsic personal or moral meaning. To believe that illness represents punishment, reward, romance, or some part of a pattern of meaning, is wrong. Attributions of meaning are only liable to increase one’s suffering, as Susan Sontag argued in *Illness as Metaphor* (1978) and *AIDS as Metaphor* (1988). Sontag insisted that the healthiest way of dealing with illness is to strip it of meaning. Or as the theologian Stanley Hauerwas (1990) writes: “The ideology . . . institutionalized in modern medicine requires that we interpret all illness as pointless” (p. 69).

This set of concepts is often called the “biomedical model.” Its demand for objective observation and measurement, coupled with the belief that simpler systems ultimately cause complex phenomena, means that medicine seeks its deepest explanations in the simplest observable systems. According to detached concern advocates, the objectivity requirement means that emotional connection with patients is dangerous and usually damaging. Critics, however, claim that precisely because of this requirement modern medicine is inhumane rather than patient-centered. However, this is an unwarranted overgeneralization: physicians who are firmly committed to these reductionist ideas are generally still motivated by a desire to help their patients as persons. They don’t consider themselves technicians and, surprisingly, many still endorse the idea of the “art of medicine.”

The “concern” in “detached concern” is intended to preserve not only the

physician's motivation to relieve suffering, but some level of personal involvement with patients. *Concern* is a weaker and more ambiguous word than *care* or *compassion*. The originators of the concept no doubt intended this. To say "I am concerned about you" may be interpreted either positively (looking out for her welfare) or negatively (questioning her behavior). In either case the phrase distances the speaker, while the alternate "I care for you" implies connection. Thus, as a modifier of detachment, *concern* doesn't contribute much to our understanding. It leaves medicine open to Cynthia Ozick's indictment in "Metaphor and Memory" (1989), where she wrote that 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" (p. 278).

This, however, is only one approach to suffering patients in medicine. Despite a perceived need for detachment, physicians almost universally agree that relationships are part of medical practice. They believe the art of medicine includes compassion, responsiveness, rapport, and "bedside manner." They believe that doctors should be concerned about their patients as individuals. In other words, physicians should connect, as well as be detached.

COMPASSION: GETTING CLOSE TO SUFFERING

As an Anglo intruder, I was unable to share Sarah Mailcarrier's symbolic world. She had symptoms—severe pain, nausea, vomiting, anorexia, edema, weakness, and shortness of breath—that could be relieved by medications, but she didn't seem to need them. How was I to understand her condition? How did she understand it? What did the condition mean to her? I had no clue. Nonetheless, I *could* connect with Mailcarrier at a more visceral level: I could empathize with her as a fellow human being.

We communicated by expression, gesture, touch, and tone. I acted respectfully (for example, by not making direct eye contact, which is taboo in Navajo society, especially when talking with an elder), while making somewhat comical use of my limited Navajo vocabulary. As a result, my visits may have made her feel a little better, although my help was minimal in comparison with her traditional ceremony. While this Navajo experience is unrepresentative of ordinary medical practice, in which doctor and patient share many cultural beliefs and expectations, Mailcarrier's case is instructive because it allows me to focus on the therapeutic power of empathy and compassion as manifested in behavior. The effect of empathy is generic and not culturally specific. In *The Healer's Calling* (1997), Daniel Sulmasy says that "true healing" requires three simple human elements: compassion, touch, and conversation. He writes that "Health care is about being there with people in their finitude and doubt, in their pain and uncertainty, respecting each one and saying that one cares, and showing by one's deeds that one really does care in all the ways one can" (p. 35).

From Empathy to Compassion

The words *patience* and *compassion* both derive from the Latin stem *pass-*, “to suffer.” One of the meanings of *patience* is the calm endurance of inconvenience, pain, or suffering. A *patient* is a person who endures suffering (although with no requirement to do it calmly or patiently). *Compassion* means to suffer with. When we identify compassion as a medical virtue, the etymological meaning is that to be a good doctor, or other health-care professional, one ought to suffer with the patient. This concept is a far cry from detached concern.

Warren Reich (1989) 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” (p. 85). Leonard Blum (1980) offers a second, synergistic definition that sheds more light on processes that occur inside the compassionate person. He writes that compassion is “a complex emotional attitude toward another, characteristically involving imaginative dwelling on the condition of the other person, an active regard for his good, a view of him as a fellow human being, and emotional responses of a certain degree of intensity” (p. 509). It is clear from these definitions that compassion involves (1) a sympathetic awareness of the other’s distress; (2) a sense of sharing that distress in some manner; and (3) an inclination to offer assistance. The latter feature motivates some persons to become helping professionals.

Writing specifically about medicine, Sulmasy (1997) contends that a compassionate physician engages patient suffering at three levels: (1) the objective, by recognizing suffering; (2) the subjective, by internally responding to suffering; and (3) the operative, by performing concrete healing actions (p. 103). Sulmasy’s first step may at first suggest the objectivity so highly valued in detached concern. In the case of compassion, however, the observing instrument (the physician) is sensitive to a wider spectrum of data. He or she is able to identify symptoms and signs of suffering-as-suffering, in addition to symptoms and signs of disease processes. To accomplish compassionate objectivity, one must develop the communication skills associated with clinical empathy. Empathy is a process by which one comes to understand another’s total “message,” cognitive and affective; words, feelings, and gestures (Coulehan and Block 2006, pp. 29–44). To put it metaphorically, empathy means getting onto the patient’s wavelength, figuring out where she is coming from, or walking a mile in his moccasins. Moreover, attainment of *clinical* empathy also requires the physician to let the patient know that he or she has actually *heard* (in other words, understood) the message (Coulehan et al. 2001). It is a positive feedback loop in which the physician titrates his or her understanding by checking back with the patient in an iterative process.

From Self-Awareness to Compassion

Self-awareness is a prerequisite for Sulmasy's second step, the subjective or internal response to suffering. Many commentators stress the need for physicians to better understand their own beliefs, feelings, attitudes, and response patterns (Coulehan et al. 2003; Frankel, Quill, and McDaniel 2003; Meier, Back, and Morrison 2001; Novack et al. 1997; Pololi et al. 2000). One of the earliest proponents of this view was the British psychiatrist Michael Balint (1972), who focused attention on the therapeutic power of the physician-patient interaction with his aphorism, "The doctor is the drug." Balint encouraged physicians to meet regularly in small groups to discuss their difficulties with patients and their personal reactions to patients. Physicians are particularly vulnerable to feelings of anxiety, loneliness, frustration, anger, depression, and helplessness when caring for chronically, seriously, and terminally ill patients (Meier, Back, and Morrison 2001). The common technique of changing feelings into "affects" leads physicians to trivialize emotions, including their own responses, and thereby to distance themselves from their patients.

The more physicians try to reverse this process by developing an understanding of their own beliefs, attitudes, and feelings, the more likely they will be able to connect with, and respond to, their patients' experience. To quote a poem by Rumi (2004):

We are the mirror as well as the face in it.
 We are tasting the taste this minute
 of eternity. We are pain
 and what cures pain, both. We are
 the sweet cold water and the jar that pours. (p. 106)

Translated into more pedestrian words, Rumi says that only by developing the ability to see ourselves in others are we able to understand them. Psychiatrist Robert Coles uses the term "moral imagination" for this process of empathic understanding, and in *The Call of Stories* (1989) he demonstrates how the study of creative literature can serve as a way of enhancing the moral imagination.

As in the excerpt from Rumi, the late-20th-century poet Denise Levertov (2003) explores the dynamic of empathic understanding in her poem "When We Look Up":

He had not looked,
 pitiful man whom none
 pity, whom all
 must pity if they look
 into their own face (given
 only by glass, steel, water
 barely known) all
 who look up

to see—how many
 faces? How many
 seen in a lifetime? (Not those that flash by, but those
 into which the gaze wanders
 and is lost
 and returns to tell
 Here is a mystery,
 a person, an
 other, an I? (p. 27)

Levertov here uses the words *pitiful* and *pity* in a way that preserves her poetic meaning but ignores an important distinction, at least with regard to the common usage of these words. Experiencing another person's suffering by means of empathy and the moral imagination leads to an experiential bond that is quite different from the attitude of pity, which carries the connotation of separateness and condescension. Even detached concern allows physicians to pity some of their patients; after all, who wouldn't be moved to pity by such unfortunate human degradation? In fact, the word *unfortunate* is often used in medicine as a code word to indicate which patients 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's syndrome and acute leukemia . . ." In such cases, the speaker indicates to her colleagues that it is appropriate for them to look down with pity upon the patient.

Levertov means something quite different, however, when she associates "pity" with "Here is a mystery, / a person, an / other, an I?" Like Rumi's poem, "When We Look Up" is about compassion, rather than pity. It captures the concept of compassionate solidarity in a more imaginative way than prose description. As Leonard Blum (1980) concludes in A. O. Rorty's *Explaining Emotions*, "expanding our powers of imagination expands our capacity for compassion" (p. 510).

TO RELIEVE SUFFERING

Compassionate Solidarity

The objective and subjective steps or components of compassion find their fulfillment in action. But does this action necessarily have to be directed toward a specific source of suffering, for instance, curing the disease, suppressing the symptoms, or directly engaging (as the Navajo *ha'atali* did) the patient's belief system? Does this mean that I could not demonstrate compassion for Sarah Mailcarrier unless I were a Navajo? Or at least that my Anglo compassion would be ineffective?

On the contrary, the creation of an empathic connection is in itself a healing action; being present to, listening, affirming, and witnessing are actions that can be accomplished, at least to some degree, prior to and independent of under-

standing the patient's cultural beliefs and expectations. There are various names for this type of relationship, but the one I prefer is "compassionate solidarity." Unlike detached concern, its focus is on the patient as a person, rather than on the disease, even though it remains systematic and objective. The American physician-poet William Carlos Williams and the English general practitioner John Sassall provide us with two literary examples of compassionate solidarity. In his *Autobiography* (1951), Williams writes 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" (p. 356). Williams describes a state of immersion in which the "I" perspective remains intact ("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. John Sassall's experience, as recorded in John Berger's photographic essay, *A Fortunate Man* (Berger and Mohr 1967), is similar to that of Williams. Berger observes that Sassall is a good doctor "because he meets the deep but unformulated expectation of the sick for a sense of fraternity." In fact, Sassall "does not believe in maintaining his imaginative distance: he must come close enough to *recognize* the patient fully." He believes that if the patient "can begin to feel recognized . . . the hopeless nature of his unhappiness will have been changed" (p. 75).

Beyond Solidarity

In the excerpts presented above, compassionate action was accompanied by a *selfless* experience. Note, however, that selflessness was self-limited: when office hours ended, Williams's ego emerged, and he reflected with detachment on what had happened during his state of immersion. Immersion in this sense is not the same as submersion in, or identification with, the patients' suffering. Rather, the experience of being out-of-myself corresponds to an empathic connection that validates the patients' suffering. While compassionate solidarity is therapeutic in itself, it also serves as an avenue for deep communication about meaningful images and symbols, when this next step is culturally possible and appropriate. In a broad sense, all therapeutic interactions with conscious patients have a symbolic dimension. Surely, Sarah Mailcarrier had created a symbolic niche for Western medicine (for example, the magic "shot" that relieves symptoms), but that niche was unrelated to the deepest and most fundamental aspects of her identity. By contrast, the Blessingway ceremony directly addressed the source and effects of suffering on her interior life. The poetry of the *ha'atali's* actions was meaningful to her in a way that might be approximated by the poetry of a priest's, counselor's, or physician's actions in ordinary health-care situations. Since suffering persons cannot help but interpret medical intervention in light of their personal beliefs, which are almost always much broader than evidence-based medicine

would dictate, medical acts have a symbolic dimension. There is, in this sense, a deep relationship between medicine and poetry:

Medicine cannot be stripped of metaphor, image, symbol, meaning and interpretation. Ill persons experience meaning in their lives and illnesses, they (like all of us) experience themselves as characters in a life narrative, and they find in medicine a vast network of healing symbols. Physicians (like poets) manipulate those culturally important symbols. They speak in metaphor. They tell stories. They conduct ceremonies (Coulehan 1992b, p. 517).

In addition to enhancing empathy and self-awareness, poetry also provides a language with which to express healing by image, metaphor, and symbol. This language can be important to physicians and other health professionals because it permits them to process difficult feelings and conflicts they experience when caring for suffering patients. By means of such imaginative self-expression, health professionals may engage in healing themselves and, thus, become more effective healers of others.

Two late poems by William Carlos Williams illustrate the step from compassionate solidarity to a self-conscious understanding of symbolic healing (Clark 2004). In “To a dog injured in the street,” Williams (1991) writes:

It is myself,
not the poor beast lying there
yelping with pain
that brings me to myself with a start—
as at the explosion
of a bomb, a bomb that has laid
all the world waste.
I can do nothing
but sing about it
and so I am assuaged
from my pain.
to believe it. (p. 255)

First, there is the flash of self-awareness. The ability to recognize suffering in others requires the imaginative leap of seeing oneself as vulnerable to suffering and, therefore, as being connected to the other. Second, the internalization of this insight in some way serves to lessen the writer’s own pain; even though “I can do nothing / but sing about it . . . I am assuaged.” (Granted, this is a poem about empathy with a dog, but the point is obviously even more powerful when a human being is “yelping with pain.”)

In “The Yellow Flower,” Williams (1991) continues:

What shall I say, because talk I must?
That I have found a cure
for the sick?
I have found no cure

for the sick
but this crooked flower
which only to look upon
all men
are cured. This
is that flower
for which all men
sing secretly their hymns
of praise. This
is that sacred
flower! (p. 257)

Here, once again, the poet acknowledges his inability to cure the sick. In addition to compassionate solidarity, however, he also offers an imaginative leap, a “crooked flower” by which “all men / are cured.” The crooked flower is what everyone longs for, each of us in his or her own way.

CONCLUSION

Suffering is the experience of distress or disharmony caused by the loss, or threatened loss, of what we most cherish. Such losses may strip away the beliefs and symbols by which we construct a meaningful narrative of human life in general and our own in particular. The vocation of physicians and other health professionals, insofar as it is possible, is to relieve suffering caused by illness, trauma, and bodily degeneration. However, since suffering is an existential state that does not necessarily parallel physical or emotional states, to relieve suffering physicians cannot rely solely on knowledge and skills that address physiological dysfunction. Rather, they must learn to engage the patient at an existential level.

However, the standard teaching in medical pedagogy is that physicians should relate to their patients with “detached concern.” This term was initially invented by medical sociologists to characterize physicians’ observed detachment from patients as persons, and their inclination to treat patients as objects rather than subjects of experience. Later, detached concern was adopted by medical educators as normative, because they believed it captured the necessity of detachment in medical practice, as well as medicine’s beneficent motivation (concern). In reality, however, contemporary medical education and practice favor a process of progressive detachment from patients that devalues subjectivity, emotion, solidarity, and relationship as both irrelevant and harmful. Such sought-after detachment (although fortunately not achieved by most physicians) almost ensures that practitioners are unable fully to appreciate and respond to human suffering.

The term “compassionate solidarity” summarizes an alternate model of the physician’s response to patients and their suffering. Compassionate solidarity begins with empathic listening and responding, which facilitate objective assessment of the other’s subjective state; requires the physician to develop reflectivity

and self-understanding; and is in itself a healing act. Going beyond compassionate solidarity, the physician may in some cases also understand the disharmony in the patient's symbolic world and, thus, be able to further relieve suffering through symbolic healing.

Reading and writing poetry, along with other imaginative writing, may help physicians and other health professionals grow in self-awareness and gain deeper understanding of suffering, empathy, compassion, solidarity, and symbolic healing.

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