

## COMPASSION: A FOUR-LETTER FEELING

A resurgence of interest in compassion and compassionate care has been a predominant topic in articles and conferences about medical education for the past few decades. The metaphorical pendulum has swung from the extreme of doctors as the aloof guardians and dispensers of complex health technology towards a heart-to-heart connection that links healer and patient in a shared experience.

Much is made of the difficulty of teaching and learning compassion. Many programs being evaluated in medical education describe compassionate behaviors and then set up processes to elicit and reinforce those behaviors. For example, one program recently mentioned in a *New York Times* article placed first year medical students at Harvard in relationships with terminally ill patients and required that they follow those patients throughout the course of their illness. Students reported that this experience was deeply moving and that they formed intense and fulfilling relationships with these patients and their loved ones. They reported it would help them to deal with dying patients.

They did not, however, report how this process would affect a five-minute interaction with a seriously ill patient and an upset family during rounds at the end of an exhausting day when they were covering for another doctor.

They did not report how this process would affect an intermittent sequence of visits from a negative, complaining chronic pain patient for whose suffering there is no absolute relief, only some amelioration.

They did not report how this process would affect a confrontation with a distraught man threatening to sue because his wife died during a routine procedure and it must be the doctor's fault because she was a good woman who did not deserve to die.

They did not report how this process would affect a meeting with a troubled and frightened alcoholic smoker who will soon be disabled by advancing liver and lung disease unless he can change his way of life.

They did not report how this process would affect their interactions with an out-of-control, raging teen-ager, wreaking havoc and screaming obscenities in a psychiatric unit.

They did not report how this process would affect their instructions to an obese single mother of four young children, weeping uncontrollably in their office when they try to explain how she must lose weight and learn to manage her diabetes, on top of all the other difficulties in her life.

They did not report how this process would affect their intervention with a crack-addicted 16-year-old, pregnant with her second child and insisting she can raise a family without an education, a husband or a job, that she can't afford pre-natal care, and that she can get her drug habit in hand without a program before the baby is born.

And yet these, and completely unforeseeable situations like these, are realistic demands on a doctor's capacity for compassion. These, and situations like these, are the ones where compassion matters most, not only for the patients' sake, but for the doctor's own well-being and satisfaction in the practice of medicine.

Compassion as an abstract ideal is easy to define and readily grasped intellectually. Compassion as a set of behaviors is easy to describe, and in an artificial exercise designed to reward and nurture such behaviors, easy to practice. Everyone would prefer to be compassionate. If teaching people *about* compassion were sufficient to raise the level of compassion in the world, most of us would have mastered it in grade school and there would be no need to consider how it can or should be taught in professional schools.

The evidence calls for re-thinking the issue entirely. Knowledge about compassion and the actual practice of compassion do not seem to have a direct relationship. Pick any doctor who, earlier in the day, screamed at two nurses and left them cowering and frustrated as she marched into a patient's room and barked out some frightening medical news, then rushed off to the next patient. Ask this doctor, "What is compassion?" She can answer the question. She can describe the behaviors. And, in all honesty, she would probably be as baffled as the hurting people left in the wake of her earlier outbursts as to why knowledge of compassion failed to influence her when she most needed it.

People who teach everything there is to know about compassion, from its spiritual, ethical, philosophical and psychological components to its practice and performance, could tell us that compassionate care does not originate in the brain and is not delivered by the intellect. All the information is stored in the brain, but the spark that ignites it in students is beyond the intellect. The efficacy and completeness of the teaching does not guarantee the awakening of true compassion.

Most teaching models nonetheless present compassion as a "subject" that must compete with other subjects for students' time and attention. The assumption is that compassion is learned by exposure to a broad array of potential external situations, which makes the learning time-consuming and complex. The *New York Times* article (8/24/00) raised the question: "Can compassion be taught in medical school?" The conclusion was murky because, as the article pointed out, "...embedding compassion in every aspect of the curriculum is not easily accomplished. Often, it is emphasized only if the basic science faculty does not have to give anything up." The article listed other obstacles to compassion: pressure for "rapid through-put" of patients, lack of good role models, a

system that rewards students for technical knowledge and “knowledge of minutiae” rather than for the ability to develop caring relationships.

What would it take to re-think the issue entirely? It would take looking beyond behavioral models of compassion and looking beyond the notion that practicing compassionate ways in a variety of settings with a variety of patients will result in a profound change in practitioners that will sustain them through all the vagaries of their professional life. It would take asking these kinds of questions: Where *does* compassion originate? What could provide each of us with certainty that we can connect with that source of compassion, regardless of what is happening around us, at any moment?

In my experience, compassion emerges, along with other profound human feelings, as a limitless internal resource for every person who understands that circumstances have nothing to do with it. But as long as our assumptions, and our teaching, link compassion with death and dying, or with the perceived image of medical professionals, or with the special situations unique to medical training, or with desperate medical conditions, or with *anything at all*, it is hard to teach and impossible to expect with any certainty. There are not enough hours in a lifetime, never mind in a medical school curriculum, to cover all the circumstances that might arise in a person’s professional and personal life that would call for compassion, and then teach that person how to deal with them.

Yet compassion is universally present, a naturally occurring state, in people who are free from conditional thinking. Everyone is compassionate *before* fearful, or personal, or judgmental, or any other sort of insecure thinking occludes common sense and erodes good will. Rather than trying to teach compassion as a set of beliefs and behaviors, we could assist people to realize their own profound human feelings and see for themselves that those feelings always arise effortlessly when they are in a secure state of mind. And those feelings always diminish and ultimately disappear as people become insecure.

To teach compassion in a way that is simple, direct and sustainable, we need only to teach people about the workings of their own minds and how states of mind come and go as their thinking comes and goes. We need to teach people that they are always able to regain a secure state of mind, just as a top spins and wobbles, but always returns to a stable stance. We need to teach people that insecurity is normal and nothing to be frightened about, but that insecure thinking takes a toll on their comfort, enjoyment, productivity and creativity if it is taken seriously or harbored. We need to teach people that they are innately sound and healthy and that compassion is intrinsic to them, and that they can know that deep within their souls and feel it in their bones.

Consider people you know who are consistently compassionate. Perhaps a minister. Or a child-care worker. Or a nurses’ aide. Or a boy scout leader. Or a neighbor. Or a grocery clerk. We are all surrounded by models of compassion; we do not have to find these role models only in our profession because they are available across all walks of life.

Consider the other qualities of these people. Are they calm? Are they patient? Are they genuinely interested in life and in others more than in their own personal lives and in themselves? Are they warm and generous-spirited? Do they have a sense of humor?

Those qualities are all part of a package that comes with the human spirit. The human spirit is abiding; it is deeper than the human condition; it is completely secure and at peace; it is rich with a universal feeling that breathes heartfelt mercy into every interaction: Love.

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