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Nurses' Interpretation of the Suffering of Their Patients[1]

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The nurse's encounter with suffering is a central aspect of nursing practice. Suffering has been associated in the literature with many life events and conditions, including pain (Blitzer, 1986; Copp, 1974), mental distress (Cornos, 1986), the threat of death (Weisman & Worden, 1976), bereavement (Fulton, 1965), medical treatment (Cassell, 1982), and poverty (Rubin, 1976). Such conditions are endemic in the various practice settings in which nurses work.

Most of the research about suffering has focused on how nurses infer the degree of the patient's suffering, operationalized as amount of pain and mental distress (Davitz & Davitz, 1981). In a series of correlational studies, nurses' inferences of patient suffering were significantly related to their own cultural and socioeconomic backgrounds, to patient diagnoses, to patient ethnicity, and to patient age (Davitz & Davitz, 1981; Davitz & Pendleton, 1969a, 1969b, 1969c, 1969d; Davitz, Sameshima, & Davitz, 1976; Oberst, 1978).

In contrast, there has been little descriptive research of how nurses experience and react to a patient's suffering. Davitz and Davitz (1981) explored this issue to some degree by interviewing groups of nurses to determine which patients elicited more sympathy and which less sympathy for their suffering. They reported that the important issues involved in nurses' response to suffering included the contrast between realism of training and

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realities of practice, the dialectic between overinvolvement (which was perceived to interfere with professional functioning) and maintaining a professional distance, and the nurses' emphasis on pain over psychological distress in evaluating suffering. Other accounts in the literature of nurses' experience of patient suffering have been anecdotal. In the face of this lack of descriptive research, the purpose of this study was to describe the assumptions, beliefs, and ideas which nurses held about the suffering encountered in their clinical practice.

METHOD

Although the interpretive method of this study was presented in a previous article (Kahn & Steeves, 1988), an iteration and expansion is in order here. Two theoretical influences contributed to the interpretive design of this study. The first influence came from Agar (1980, 1986), whose work led to the assumption that the beliefs and ideas about suffering that nurses shared as a group would be embedded in the discourse or natural language that nurses used in thinking and talking about suffering. The second influence was Benner's (1984, 1985) work, which suggested that elicitation of exemplars was a useful way to gain access to nurses' knowledge of their clinical practice.

Sample

A sample of 26 incoming graduate nursing students was selected for two reasons. First, these students were thought likely to be reflective and verbally adept. Second, as Schutz (1962) noted, a group in transition between two social roles or cultural identities (in this case, clinical practice and graduate school) is particularly good for eliciting thoughtful reflection on the identity just relinquished. Participants were self-selected through a letter of invitation, and informed, written consent was granted by each informant. At least 1 year of full-time nursing practice was required to be included in the sample. Procedures to maintain participant confidentiality and protection of their rights were built into the study procedures and approved by a university committee for the protection of human subjects.

The sample consisted of 20 females and 6 males, ranging in age from 24 to 39 years, with a mean age of 32.1 years (SD = 4.8). Years of nursing practice ranged from 2 to 16, with a mean of 7.6 years (SD = 4.1). The practice experiences reported by the participants ranged across a wide variety of settings, from intensive care to home health and from obstetrical units to

hospices. The majority of participants (19) reported experience in at least two different practice settings.

Data Collection

Data were collected from an audiotaped interview conducted by either of two interviewers. To ensure reliable comparison of interview data between interviewers, a standardized interview schedule with specific prompts was developed. The schedule structured the interviews around three areas of content: (a) the production of a list of words/phrases that each participant used synonymously with suffering along with a contextual description, (b) the specification of semantic principles underlying the meaning of suffering for each participant, and (c) the collection of clinical exemplars or prototypical examples offered by the participant from his or her clinical practice that illustrated suffering. The interview schedule was refined through pilot interviews in which each interviewer observed and criticized the other's technique. Content validation of the schedule was attempted by having an independent expert in qualitative methods review the instrument.

Although the interview schedule served as a guide, the interviews were open-ended. Participants were allowed to add material tangential to the three content areas. Also, the interviewers added a dialectical dimension to the interview by sharing their interpretations of participant's remarks with the participants for validation or clarification.

Analysis Data

Data analysis, which was guided by the work of Spradley (1980) and Kockelmans (1975), began after all interviews were completed and transcribed. The first phase of analysis involved coding or extracting statements that each participant made that described aspects of suffering. These statements remained emic in that the actual words of the participants were not altered or interpreted. Statements were not necessarily coded line by line or sentence by sentence but rather in the most parsimonious form that retained contextual meaning. These emic statements included synonyms, phrases that defined elements of suffering such as cause, phrases that set conditions on or limits to previous remarks, and stories about patients that illustrated suffering.

In the next phase, the emic statements were grouped according to observed similarities. Each group was labeled with a category name, and the rules for inclusion in that category were specified.

In the final phase, the categories were grouped into themes according to theorized or etic similarities. Interpretation of the meaning of the data as a whole was based on these themes. At each step in the analysis, examples or images from the intact interviews were reexamined in order to validate the interpretative process.

Bias Control

Several checks to control investigator bias and increase the validity of study findings were used. Two of the investigators separately coded the emic statements from approximately one third of the transcripts (per investigator) chosen at random. No discrepancies in amount or type of statements were noted. Second, the grouping of emic statements into categories required agreement between all investigators, thus providing some consensual validity. Finally, the remaining transcripts were coded and the categories that were developed in this portion of the data were compared with the previous categories. No discrepancies were noted.

No categories contained emic statements from less than two participants. The mean number of participants contributing statements to each category was 8.1 (range = 2 to 12).

A panel of three experts in qualitative methods attempted to match randomly selected emic statements using the categories and inclusion rules. The mean agreement between the judges' and the investigators' schemas was 90.7% of the statements; no judge scored lower than 88% agreement.

FINDINGS

The composite data collected from the 26 informants can be interpreted or understood as falling into clusters around several themes. These clusters were not static. Informants ranged freely from theme to theme and back again. They did not always start with the same theme or move in the same direction. However, the authors became aware of a thematic progression, an ordering of the clusters, that made sense of the data. While it is not possible to say that this thematic progression existed in a complete and comprehensive form in the mind of any single informant, this ordering of themes makes understandable the encounter with suffering which was enacted in the discourse or collective speech of the informants as a group. The progression of themes began with informants conceiving of suffering as a medical condition.

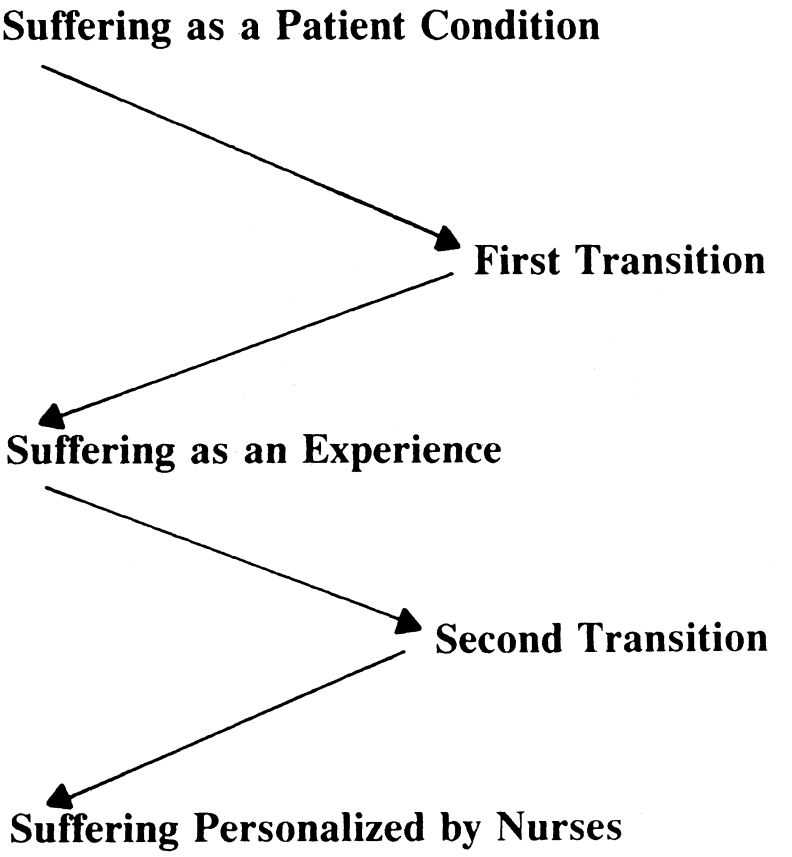

Figure 1: The data interpreted as a progression of themes.

Several other themes represented intermediate steps, and the progression ended with informants interpreting suffering as their own, deeply affecting personal experience. The progression is depicted in Figure 1.

Suffering as a Condition

Conceiving of suffering as a condition was a natural place for informants to begin. The dominant force in most nursing workplaces is medicine and the "medical model" requires phenomena to be viewed in terms of conditions and treatments. Indeed, the investigators, as members of the nursing culture

they were investigating, began this part of the interview with the statement "We are interested in a patient condition we call suffering."

The causes. Suffering as a condition was described by informants in terms of its causes, its course, and its effects. As might be expected, many informants described loss of bodily intactness as a cause for suffering. One informant described a suffering patient as "basically one big abscess from the belly button down." There were patients with "huge burns," patients who were "emaciated [and] looked like skeletons," and those with "tumors all over." In this same vein, one informant talked of the ultimate loss of intactness: "I think that the worst suffering I have had to deal with in patients is when they are facing death." A corollary to this is the not surprising idea that pain is a major cause of suffering. What is surprising is that nausea was the other symptom associated consistently with suffering.

Psychosocial phenomena may also cause suffering. The example cited by informants was social isolation: "That woman suffered. She didn't have anybody. She had no really close friends. The one neighbor she had that she could kind of count on turned her back on her."

The course. Suffering as a medical condition is chronic; "it is kind of a long-term thing that is slow to heal." Informants offered specific examples such as the "man who was just dying by inches with COPD [chronic obstructive pulmonary disease]; he had been bed-bound for a couple of months," or the man who "was intubated, on a ventilator for months in the intensive care unit." Phenomena such as childbirth and simple fractures were recognized as involving pain but not suffering because they are short lived.

The effects. Suffering results in certain social behaviors and changes in functioning. The behavior of people suffering was alternately described as "whiny," "crying," "screaming," and "moaning," or "withdrawn," "forlorn," "sad," and "lethargic." The informants believed suffering "limits . . . lifestyle" and imposes "restrictions on some level." "It doesn't allow you to live your life the way you want to." Examples offered were of a woman who must give up her role as mother and head of the house, a man with COPD who cannot go outdoors anymore, and a woman faced with the necessity of going into a nursing home.

First Transition

The notion of suffering as a medical condition was not satisfying for the informants. In the first transitional phase, they identified characteristics of suffering that cannot be understood in terms of the features of a medical condition. One obvious characteristic is that the person must be conscious to

suffer. Patients have tuberculosis or cancer whether they are aware of it or not. However, suffering is inextricably tied to knowing. As one informant put it, "When he [the patient] slipped into a coma I took it as evidence that he wasn't suffering anymore." Other patients went to sleep "and slipped away" into death or were so badly damaged by a stroke that "they didn't know any different." These people did not suffer.

Informants found suffering different from medical conditions in that it was difficult, often impossible, to assess. Suffering was not open to investigation and diagnosis as were medical conditions. Interviews contained statements such as "I think that there must be some way to measure that [suffering] and there is not," "[some patients] don't give you any signs they are [suffering]," and "they [suffering patients] can be in tears or just quietly reading a book."

To many of the nurses, suffering was not only difficult to assess but was defined by the individual patient and thus varied from person to person. This notion truly precludes understanding suffering as a medical condition. As the informants put it, "Everyone suffers in a different way" because "suffering . . . is so personal." Some informants suggested that individual variations in suffering depended on self-concepts or "emotional attitudes." Suffering was not determined directly by a symptom or a situation but by the patient's "response to the existence of [symptoms]," or the patient's "perception" or "interpretation" of the pain, nausea, or other condition. This interpretation or perception in turn depended on how it affected the patient's "belief system" or whether it damaged any "part of his real identity."

Some informants pointed out that, unlike medical conditions, suffering can be experienced by groups as units as well as by individuals. Whole families can suffer because of the problems of one of its members. One informant offered the example of a "middle-aged woman dying of cancer." The informant made the point that "she wasn't suffering as much as the family." Other informants also offered examples of what one called "family conditions" that constituted suffering. Clearly, suffering is different from a medical condition because it can arise in the relationship between people making it possible for a family to suffer, while medical conditions are confined to the bodies of individual persons.

Suffering as an Experience

Because they realized that too many aspects of suffering were not open to objective, detached scrutiny, informants were unable to rest satisfied with the concept of suffering as a condition. They began viewing suffering as an

experience of patients rather than a medical condition to which patients were subject. With this recognition came an exploration of the characteristics of suffering as a patient's experience.

Informants recognized that for some patients, the experience of suffering was characterized by the necessity to perform a "balancing act" between two unpleasant alternatives. One nurse told of a woman who "was willing to give up her pain medication [which was making her too drowsy to function] in order to stay out of a nursing home." Another patient wanted to die because she "didn't have any energy to cope anymore," but "she couldn't let go and die because God knows what would happen to her family."

Some informants discovered a classically tragic characteristic in the experience of suffering. For them, the most poignant examples of suffering had an ironic twist to them. For instance, there was the story of the man who came into a urology unit for a penile prosthesis:

> He was a pretty severe diabetic . . . [but] he was very healthy coming in. He was in relatively good control of his diabetes. But, he ended up having his penis removed because it was necrotic. . . . What started out being a positive thing that he and his wife would be able to have sex in the future, ended up being just absolutely devastating. Most people go home as happy as a clam, but for the ones who [become necrotic], it is just devastating. The thing that was hard, too, I think, was that we didn't see him grieve a lot over it. He was always just kind of chipper about it, and we knew that he must just be going through hell.

One characteristic of the experience of suffering is that one does not feel in control. An informant explained that suffering "connotes that things are kind of out of control, panic, deteriorate, snowball." This loss of control was what distinguished between pain and suffering. One nurse ventured that "the fear of loss of control may be worse than pain." Another said that pain is different from suffering because "you can do something about it."

To many informants, the lack of control inherent in suffering is tied to knowledge. People suffer when they "don't understand what is going on," when something that is happening is "unexplainable," or when people "don't know what is going to happen."

Coping is closely tied to suffering in that as "coping mechanisms start to deteriorate," one begins to suffer. In fact, as one informant put it, "Something may seem disastrous to me, but if they are coping well, then I would not say they are suffering." As this group of informants began to explore what they meant when they said a person was coping, the notion of acceptance became apparent. According to one nurse, "I think the worst suffering that I see is an emotional thing when they [patients] can't accept what is going on." This acceptance, when it does occur, manifests itself in interesting ways. A patient

dying of cancer was described as no longer suffering because "she was at peace inside." Another model of acceptance was "having a sense of humor and laughing at yourself."

Second Transition

Even after the transition from suffering as a medical condition to suffering as a patient experience was compete, this group of nurses still was not at ease. Suffering is laden with emotion, not only the emotions of patients but of nurses themselves. The term *suffering* was troublesome for many nurses. The term was subjective and carried emotional weight that many of the informants wanted to eliminate. Some of the objections were mild. The word was not "tangible" and was "descriptive rather than defining." These objections hearken back to seeing suffering as a medical condition, but the stronger objections to the word were based on the fact that it was "emotional" and "soft."

When the informants talked about the word suffering as having a "bad connotation," it became clear that they were talking about their own emotional response to the word. One informant said, "The word is too dramatic or something. Or melodramatic. Maybe that's it. I don't like it." Another said, "It sounds too churchy or Biblical or something"; another simply said, "It's too negative."

It was not just the word that bothered these nurses. It was also that when they were faced with the suffering of their patient, they often felt helpless. This sense of helplessness was evident in statements such as the following:

> "Suffering . . . implies that there is nothing that can be done to help them."
> "I just didn't know what to do for him. I felt real helpless."
> "It is very depressing to take care of them (suffering people) because a lot of times you can't help . . . you can't comfort them."

Suffering Personalized

The informants recognized their own emotions in their reaction to the word suffering and in their feelings of helplessness. It was a short but difficult step from that realization to the personalization of suffering. The suffering became their own.

This personalization is demonstrated clearly in the assertion by some informants that they (or at least the profession they were in) caused some of the suffering. As one informant put it, "We [nurses] induce suffering some-

times in an attempt to be therapeutic," or as another said while talking about painful treatments she had to give to a patient, "I don't see why we have to do this to this guy. I don't see any reason for it." Some nurses were more descriptive of the suffering caused by the nursing unit in which they worked: "starvation . . . sleep deprivation . . . all the things that go along with an ICU."

With the recognition of their own emotional response to suffering and the realization by some nurses that nurses contribute to suffering came the understandable desire to leave nursing. For some, it was the desire to leave certain settings: "We're just contributing to the suffering. . . . I think it is the reason we all leave ICU after a while." Others were tempted to leave nursing altogether. This temptation was well illustrated in a story about a 16-year-old boy who was hit by a train on his way home from football practice.

> He had been crossing a railroad track, rushing to his football practice on his bike, got between two cars and they backed up and squashed him. He had major trauma and was in acute renal failure. He had gone from dialysis to surgery, dialysis to surgery to dialysis, then to our unit. He ended up going into heart block, and we couldn't get him back. When I first met him, I went to the dialysis unit and introduced myself. His eyes opened up and they were black as he looked up at me. He was intubated and had a "G" suit on. . . . So terrified. Just terrified. I held his hand and did whatever I could for him just to let him know that I was there and I cared. . . . By the time he was going through the first, second, and third heart block, he was unconscious. So I don't see that he was suffering, but his father and his brother; it was just awful. I mean they were just sobbing over his bed. To me that was suffering. Sixteen years old. I mean his whole life was gone. I almost left nursing because of this. I never work in peds anymore.

DISCUSSION

The findings presented in this article indicated that the meaning of suffering to nurses is not static. Rather, the evidence suggests that nurses' views on the essential nature of suffering undergo modification as they become socialized into the work culture of nursing and the meaning of being a nurse.

Belief Systems, Clinical Experience, and Time

The meanings attributed to suffering are cognitively structured as a result of an interplay among three influential factors: belief systems, clinical experiences as nurses, and temporal circumstances. Given the power of the

biomedical model of disease to influence nursing work in hospitals (Benoliel, 1977) and the instructional programs of schools of nursing (Quint, 1967), it is not surprising that initially nurses defined suffering as a condition that had causes to be determined, a time course of some sort, and effects that could be observed. The descriptors which nurses used to characterize these components of suffering came directly out of their observations of and experiences with patients.

Contacts with patients also contributed to a revised perception of suffering as a subjective experience of the patient, not amenable to assessment by the nurse, and highly personalized in its meaning to that patient. Movement from viewing suffering as a condition to suffering as an experience required some period of time for exposure to a variety of patient situations. As well, this shift required that the nurse's views of suffering be mediated through a different belief system—one of suffering as a variable human experience, affecting either individuals or groups. The emphasis given to individuality of expression of suffering and to the importance of loss of control likely are reflections of the American cultural system in which an ideology of individualism is a powerful governing force (Meyer, 1988).

The shift to personalize suffering for nurses appears to represent a cognitive conflict between the objective ideals of the medical model and the subjective realities of the suffering experience inferred from observations of patients and experienced in their own feelings of helplessness when faced with tragic and difficult patient circumstances. An awareness of their own contributions to the suffering of patients not only was distressing emotionally but was not in keeping with an idealized image of the nurse as a professional provider able to comfort and give help. The nurses' descriptions of personalized suffering are congruent with Vachon's (1987) findings that health care providers who believed they had a mandate to control patients' symptoms experienced high stress levels when they were unable to do so.

Passage of time and critical experiences with certain types of patients were essential to the formation of these different interpretations of suffering. Yet there is no evidence that *suffering as an experience* and *personalized suffering* replaced the idea of *suffering as a condition*. Rather, the findings suggest that these different meanings of suffering could exist simultaneously in the subconscious functioning of the mind, being drawn to the surface selectively in response to a nurse's current clinical situation. The evidence also suggests that continuing contacts with patient situations that lead to personalized suffering in the nurse could contribute to decisions to withdraw from clinical nursing.

The extent to which newly graduated nurses encounter difficult patient situations depends on the characteristics of the hospital units to which they are assigned. Such encounters are likely to occur in settings in which nurses must provide care to large numbers of patients who suffer from severe and unrelieved mental or physical anguish—patients referred to by Yondorf (1975) as the declining and the wretched.

Relationship to Existing Theories

Three theories appear to have relevance to these findings: Marris's (1974) theory on structures of meaning and human adaptability, the status passage theory of Glaser and Strauss (1971), and Parke's (1971) theory on psychosocial transitions. According to Marris (1974), the human ability to respond to new experience, such as patient situations encountered by newly graduated nurses, depends on a cognitive-emotional structure through which the person is able to maintain a sense of continuity through giving meaning to that experience. Not surprising, the nurses' initial interpretations of suffering were established through a familiar frame of reference—the medical model—that provided a sense of continuity with past experience.

Yet this structure of meaning did not hold up well when the nurses' experiences with patients caused them to redefine suffering, first as a patient experience and later as their own. These changed views on suffering did not fit well with the assumptions of the medical model. Rather, they appeared to be revised structures of meaning resulting from a crisis of discontinuity and a discrediting of familiar assumptions. In Marris's theory of adaptability, reestablishment of continuity following the loss of familiar assumptions requires a process of bereavement through which understanding of the situation is revised and emotional responses are attenuated. Further consideration of Marris's ideas about loss and change in relation to nurses' interpretations of suffering and identity development would be useful for theory development about human adaptations to life changes that threaten established beliefs about the self.

The theory of status passage by Glaser and Strauss (1971) provides a useful framework within which to examine how the meaning of suffering is learned through the status passage of newly graduated nurses in the hospital context. This theory provides a perspective on the temporal and contextual elements that need to be considered in understanding the processes of change reported by nurses and their revised views on what these changes mean.

Parke's (1971) theory of psychosocial transitions also is relevant to this research, providing another perspective on viewing change over time. In his view, psychosocial transitions are provoked by major changes in life space that require abandonment of old assumptions and both internal and external changes aimed toward improving the fit between the person and the person's environment. Understanding the psychosocial transitions of nurses during their early years of socialization in the work arena would add to knowledge about how nurses incorporate the concept of suffering into their identities as nurses and how they learn to cope with the suffering of patients and with their own.

Implications for Research and Practice

These findings were based on interview data with nurses who, for whatever reasons, had decided to seek advanced education. The extent to which similar meanings would be found for nurses currently in practice in hospital settings is a logical next step in research. In addition to validation (or invalidation) of these results, such research could be designed longitudinally so as to capture some of the environmental and temporal variables affecting the nurses' encounters with different types of patient situations. Of particular interest would be research designed to clarify the kinds of organizational circumstances that are supportive of nurses when patient situations stimulate feelings of helplessness and insecurity. Difficult patient situations in hospitals are not going to disappear, but understanding the influence of these situations on how nurses structure their beliefs about themselves as nurses and their decisions about whether to remain in nursing is information with potential value for policymakers and managers of health care delivery systems.

Turnover of nurses continues to be a major problem for many hospitals in the United States ("AHA Sees RN Shortage Easing," 1989). The extent to which personalized suffering as found in this research is a contributor to nurses' decisions to withdraw from hospital work is not clear. Yet conceivably, it could be a factor of some importance. For example, in her study of occupational stresses in health care work, Vachon (1987) found that 11% of the reported ways of coping with work stress was to leave the work situation and another 11% was to avoid or distance oneself from the patient or family. By learning more about the nature of nursing work—particularly the effect of difficult patient situations on nurses themselves—perhaps ways can be

found to develop working environments that counteract the use of turnover as a way of coping with a stressful work situation.

NOTE

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Commentary

Suffering is a complex human response commonly encountered in nursing, and it represents a multidimensional phenomenon for investigation. The authors have made a notable contribution to nursing science through their well-designed study of this concept, specifically focused on nurses' own interpretation of suffering. The research methods serve as a model example of qualitative research based on reliable and valid procedures. The interpretation of findings is enhanced by the presentation of a progression of themes which offers a model for future research.

The substantive value of this work is the distinction between patients' experience of a phenomena and nurses' interpretation of that phenomenon. The patient's experience of suffering is the antecedent to the nurse's experience, yet the two phenomena are separate. Similar to our knowledge of the concept of pain, the experience of suffering is an individual experience and can only be measured by the experiencing person. The authors have avoided the lethal mistake of evaluating nurses' interpretations of *patients'* suffering and, rather, have made a more valuable contribution by describing nurses' interpretation of their *own* suffering as derived from experiences with patients.

The authors' comparison of this study to three existing theories is also exceptionally well done. The potential for application of Marris's theory on structures of

meaning and human adaptability is significant. In the midst of the current nursing retention crisis, nurse leaders have cautioned our reliance on simple explanations and solutions for what is, in fact, a very complex problem. The examples provided in this study illustrate cases of critical turning points in a nurse's professional life. An observed experience of suffering threatens previous assumptions and a loss of identity which may result in exit from nursing.

Application to Parke's theory on psychosocial transitions is also very interesting. Coping with suffering of patients and with their own interpretations of suffering is a monumental task. The authors point to the implications for nurses during early socialization in the work area. It would also be interesting to explore how nurses become socialized to suffering while students. Do current curricula, based largely on medical models and promoting cure, create an expectation for nursing students that a suffering patient indicates nursing failure? Can we, in fact, intervene with nurses' interpretations of suffering before they enter the professional arena?

The authors acknowledge the limitations of the sample as a biased group representing only nurses enrolled in a graduate program. This limitation cannot be overstated. These nurses represent a select group and likely are very dissimilar to the typical staff nurse. Beyond personal characteristics which have motivated them to seek graduate education, there are important environmental differences that affect the interpretation of suffering. Graduate students exist in an environment that promotes introspection, self-reflection, and conceptual thinking. The intellectual environment and social support of faculty and peers are a rich resource for interpretation of experiences such as suffering. Staff nurses are likely not afforded such an environment. Replication of this study in other populations would be valuable in building on this knowledge.

Overall, this is an exceptionally well-written article with important implications for nursing education, administration, and practice.

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Response by Steeves

Dr. Ferrell's perceptive comments are greatly appreciated, especially her remarks concerning the separation of the experiences of the nurse from the experiences of the patient. It was quite clear that sometimes nurses were describing their own suffering, and although their suffering may have been precipitated by the suffering of patients, it was something that was happening to them. These nurses did not seem to be suffering for or with their patients but rather in response to what was happening to their patients. For example, in the case of the nurse and the 16-year-old boy who was

hit by a train, the nurse appeared to be suffering because of the injustice of what had happened to the boy: "Sixteen years old . . . his whole life was gone."

This makes for a difficult set of problems. What is the relationship between an experience and an observed experience? Do vicarious experiences cause suffering? Can compassion and empathy be the source of suffering? Perhaps what is called for is a new way of looking at suffering. If suffering is conceptualized as an experience, something that happens to people, then the suffering of nurses when they witness the suffering of another is difficult to explain. If, however, suffering is thought of as a way of experiencing the world rather than an experience, this phenomenon becomes more understandable.

To rely once more on Marris (1974), suffering may be understood as the vision of the world that exists between an old meaning system that has been challenged and the revised meaning system that will take its place. Inside that gap one can glimpse meaninglessness. The gap is a time when events are not explainable by any system of understanding, and one has to consider the arbitrariness, the contingency, of all explanatory systems. To put it another way, perhaps suffering can be understood as a failure of meaning. A person who is suffering continues to experience the world; time passes and events occur, but the events do not make sense. They are without meaning. The kind of senselessness and meaninglessness that is associated with insanity is not what is meant here. Not all the rules by which one makes sense of reality are changed; probably the only rule missing is the one that helps answer the questions that begin with "why?" Why do nurses, who are supposed to help people, torture them? Why does a young boy have to die so young and so violently?

A person can look at tragedy in their own life or in the life of another and see a Sophoclean or Shakespearean tragedy wherein the actions of men and women, no matter how cruel and violent, are played out against a world that is ultimately reasonable, comprehensible, and, if not merciful, at least just. If for some reason, such as the innocence of the victim, or the degree of pain and isolation, or the sheer number of victims (*6 million* is a familiar example), the ultimate justice of the universe is called into question, then these tragedies are experienced in a different way and the person suffers.

This leads to a second important point made by Dr. Farrell. The informants for the study were a select group. They had chosen to return to an environment that encouraged personal as well as professional reflection. Did this tendency toward self-reflection and thought that brought them back to graduate school also predispose them to suffer? That is, one must first be willing to ask the question "Why?" when faced with tragedy before one can come to realize there is no good answer. Also, it is important that these informants did not leave nursing; they were, in fact, returning for an advanced degree. Perhaps it is their tendency toward self-reflection that allowed them to look at the abyss of meaninglessness and pull themselves back from it with a renewed sense of coherence, a coherence somehow based on a confidence in their own being. All this remains at the stage of conjecture, but the empirical questions suggested are fascinating. Because of this Kahn, Benoliel, and I, as well as other scholars perhaps, will continue to investigate these issues.