



The limits of pity in *Bartleby* and *Moby Dick*

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ABSTRACT

Failures in the emotional connection between doctors and their patients tend to be reported in terms of compassion fatigue, burn-out, secondary trauma and depression in overlapping and somewhat interchangeable ways. In *Moby Dick* and *Bartleby*, Melville interrogates the culturally accepted descriptions of pity and explores the reasons for the limits in human pity he observed and depicted. In an attempt to understand whether the feelings of pity that a patient's suffering can evoke in physicians are sustainable, desirable, or counter-productive, Melville's narratives, along with that of a woman who, while living with advanced cancer experiences the breakdown of a key medical relationship, will be considered.

[Doctors are] talking to someone who just got diagnosed and is freaking out. They're talking to somebody who is number ten on the list, and dying. They're talking to somebody who looks as if she might get through. They're talking to—how can any one human hold that in his being and do it day after day after day?

Inattention on the part of a physician to elements of personal style can lead to emotional exhaustion.^{2–4} In addition to scientific knowledge and techniques, physicians use interpersonal skills to encourage the patient to tell his story,^{5,6} to assist in decision-making,⁷ to support compliance with difficult and painful treatments by building and maintaining a treatment alliance^{8,9} and to monitor and promote psychological well-being.^{10–12} A physician therefore uses the “self” as an instrument in diagnosis and treatment but, in doing so, opens the door to complications because personal history and emotional style affect relationships with patients.^{13,14}

For instance, when patients experience protracted suffering the physician's impulse to rescue may result in feelings of failure and frustration. Physicians may become over-involved, then abruptly disengage when rescue and restitution prove impossible.

Herman Melville's narratives in *Moby Dick* and *Bartleby* interrogate the culturally-accepted descriptions of pity and explore the limits of pity in human relationships. The narrator of *Moby Dick* is Ishmael, a novice whaler though experienced sailor, who ships out with the *Pequod*. Ahab, the ship's enigmatic captain is possessed by fury after being mutilated by the white whale Moby Dick. Ishmael observes and relates Ahab's unredeemable suffering and its tragic effects. The narrator of *Bartleby the Scrivener* (hereafter, “Bartleby”) is a nameless lawyer who runs a law practice on Wall Street in New York. Bartleby answers an ad for help placed by the lawyer and is hired although he seems like, “one of those beings of whom nothing is ascertainable...”¹⁵. One day the lawyer has a small document he asks Bartleby to

examine. Bartleby responds, “I would prefer not to.” The lawyer assigns the job to someone else in the office, but, struck by the unexpected response, begins to watch Bartleby in a careful if not fascinated manner. Finally, to bring these issues into the clinical setting, “Louise,”¹⁶ a woman living with advanced cancer, tells about the failure of a medical relationship at a critical juncture.

Much of the literature on burn-out, compassion fatigue, secondary trauma, depression and demoralisation describes what ails physicians when they reach the limits of their ability to feel connected to their patients.^{15–24} In these discussions, empathy, sympathy, compassion and pity are defined in varied and overlapping ways. In general, though, *empathy* is used to describe a distanced and professional attitude—although the term is variably used to express a human trait, a professional state or a special relationship²⁵—whereas *sympathy* indicates closeness to the patient's experience that risks a loss of perspective and an increase in feelings of helplessness and vulnerability. *Compassion* implies a spiritual and ethical aspect or practice encompassing a concern with fairness and a “there but for the grace of God go I” attitude when witnessing another's suffering.^{26–30} All of these terms form nacre layers around the grain of *pity* with its linguistic heritage in piety.

Melville's portraits of madmen in *Moby Dick* and *Bartleby the Scrivener* illuminate the effects of Ahab's and Bartleby's suffering on those who narrate their stories. The narrators' reflections and descriptions can help physicians to understand their own responses to patients' suffering.

In life the pitiable may become targets of sentimentality—the extension of Christian compassion in a belittling manner to a group otherwise seen as alien—an extension which includes these others in the social space only through pity.³¹ Pity may devolve into a distancing sentimentality in which the one who pities feels impervious to the misfortunes of the pitied.

Melville avoids sentimentality and preserves respect for his madmen through his narrators' initially neutral attitudes. The reader gradually becomes aware of both the awfulness of the situation in which Ahab and Bartleby find themselves and the hard-won shreds of dignity that remain to each man. Ahab and Bartleby appropriate and distort their social relationships just as many of our patients suffering with undiagnosed and unrelieved symptoms do. Melville's tales provide us with

¹⁶“Louise” was interviewed for a qualitative research study, “Perspectives of Patients with Life-threatening Illness” that began in 2001. The IRB of the Dana-Farber Cancer Institute/ Brigham and Women's Hospital in Boston, Massachusetts, approved the study. All participants in the study gave written informed consent for use of their interviews in print and audio form.

an opportunity to think about the workings of emotional connection (and disconnection) between each narrator and his madman. These two stories illuminate different processes by which physicians withdraw from clinical situations that frustrate their wishes to heal.

In *Moby Dick* the reader is confronted with her own wish for distance when faced with another person's relentless pain. Ishmael's detailed and empathic description of Ahab's suffering tempts the reader to withdraw, to shy away from the personal implications and thus to avoid an identification with Ahab that would compel her to recognise her own vulnerabilities and limitations. *Bartleby* presents us with the related problem of sustaining pity in the face of our own failures to effect restitution and holds up a mirror to our frustration, projection and (denied) wish to punish those whom we fail to cure.

Melville interrogates the culturally accepted approaches to unmitigated suffering in others in the structure of his language. He builds his portraits of madness by enacting the circular all-consuming nature of each man's "soul sickness". For example, in *Moby Dick* he uses repetition (often in parallel constructions):

The White Whale swam before him as the monomaniac incarnation of all those malicious agencies which some deep men feel eating in them, till they are left living on with *Half* an heart and *half* a lung ...

That intangible malignity which as been from the beginning; to whose dominion even the modern Christian ascribe *one-half* of the worlds; ...

All that most maddens and torments; *all* that stirs up the lees of things; *all* truth with malice in it; *all* that cracks the sinews and cakes the brain; *all* the subtle demonisms of life and thought; *all* evil, to crazy Ahab, were visible personified, and made practically assailable in *Moby Dick*.³² [emphasis added]

The repetition of "half" pounds on partiality, a fallen state, and division—division of the world between good and evil and division of Ahab from his intact body, division from his sanity, separation between his reality and the reality of his fellow men. This focus on the damaged and divided is then counter-balanced and simultaneously manifestly reinforced by the six chanted "alls".

To say "all" is to say what can never be. "All" logically brings its opposite into the equation simply by its impossibility. "All" is a monomaniacal assertion. It overstates, throws doubt on itself and immediately causes the reader to think "none". In this way, Melville enacts Ahab's madness in language even as he describes his mania—illuminating the vast chasms between "all" and "none" even as he shows us that they become one at the core of Ahab's insane soul.

Melville shows us how Ahab's preternatural focus and demonic energy attempts to balance an inner sense of abject emptiness. Ahab—injured, suffering and irrevocably divided from his undamaged self—tries to contain within himself these extremes. Failing that, he projects his sense of injustice and evil onto the white whale. Ishmael calls him a "deep man", reinforcing the reader's sense of a unique being, a heroic man, overthrown. The reader becomes witness to great gifts overthrown by terrible injury. We share Ishmael's recognition of irredeemable damage that binds us to Ahab through our shared vulnerability to injuries that are beyond restitution. Melville holds us in relationship with Ahab through Ishmael's mesmerising description, even as he shows us why we feel a need to break away from Ahab as a person to view him as a symbol.

In *Bartleby*, Melville takes on the limits on human pity directly. The reader seamlessly merges with the nameless narrator who describes Bartleby in a paragraph built on repeated images of waning, negation, passivity and death:

I now recalled all the quiet mysteries which I had noted in the man. I remembered that he *never* spoke but to answer; that, though at intervals he had considerable time to himself, yet I had *never* seen him reading—no, not even a newspaper; that for long periods he would stand looking out, at his *pale* window behind the screen, upon the dead brick wall; I was quite sure he *never* visited any refectory or eating house, while his *pale* face clearly indicated that he *never* drank beer like Turkey, or tea and coffee even, like other men; that he *never* went anywhere in particular that I could learn; *never* went out for a walk, unless, indeed, that was the case at present; that he had declined telling who he was, or whence he came, or whether he had any relatives in the world; that though so thin and *pale*, he *never* complained of ill health. And more than all I remembered a certain unconscious air of *pallid*—how shall I call it?—of *pallid* haughtiness, say, or rather an austere reserve about him, which had positively awed me into my tame compliance with his eccentricities ...³³ [emphasis added]

"Never" occurs seven times in this description with three "pales" and two "pallids".

The narrator becomes entranced by Bartleby's extreme negativity describing his own state as one of "tame compliance with his [Bartleby's] eccentricities". In his deprivation, Bartleby resembles an over-scrupulous ascetic. The list of all the distracting social and self-sustaining things he does not do makes it difficult to imagine Bartleby's experience. Yet Bartleby, for all his negativity, has a "haughtiness" that enforces compliance from the narrator. We find ourselves in the presence of something or someone so unsparingly devoted or consumed by a single goal or idea that we fall back feeling vaguely defective.

Melville pushes the limits of our attempts to identify when he underscores the equivalence between Bartleby and the dead brick wall of his reveries. The reader begins to feel oppressed, to lose patience, with Bartleby and with the narrator who continues to be tamely compliant. Our impatience indicts us when later the narrator begins his own meditation on pity fatigue.

My first emotions had been those of pure melancholy and sincerest pity; but just in proportion as the forlornness of Bartleby grew and grew to my imagination, did that same melancholy merge into fear, that pity into repulsion. So, true it is, and so terrible too, that up to a certain point the thought or sight of misery enlists our best affections; but, in certain special cases beyond that point it does not.³⁴ (p 18)

Melville sets up pairs of conflicting feelings—melancholy/fear, pity/repulsion—which usually function as a logical simplification by excluding the middle (ie, we choose either melancholy or fear, pity or repulsion). However, in Melville, this "either/or" rhetoric becomes a network of alternative pairings. This complicates rather than simplifies, just as denial that protests too much increases suspicion and ambiguity.³¹ Thus, we understand that our narrator feels melancholy *and* fear *and* pity *and* repulsion in precisely graduated and shifting proportions. We also share these conflicting feelings.

In *Moby Dick*, too, Melville lists emotional states, abutting them to enact the extremity and hopelessness of Ahab's madness:

Small reason was there to doubt, then, that ever since that almost fatal encounter, Ahab had cherished a wild vindictiveness against the whale, all the more fell for that in his frantic morbidness he at last came to identify with him, not only all his

bodily woes, but all his intellectual and spiritual exasperations.³² (p 200)

Here, as in *Bartleby*, Melville creates surprising pairings that complicate the portrait of Ahab: he cherishes and is frantic, he is vindictive and identified with that which has dismayed him. These ambivalent, human, complicated portraits prevent the reader from retreating into oversimplifying stereotypes that minimise both the protagonist's suffering and the closeness of that anguish to the reader.

This pairing of seeming opposites that holds the reader in the middle ground is particularly effective in Ishmael's description of how Ahab became mad:

It is not probable that this monomania in him took its instant rise at the precise time of his bodily dismemberment. Then, in darting at the monster, knife in hand, he had but given loose to a sudden, passionate, corporal animosity; and when he received the stroke that tore him, he probably but felt the agonizing bodily laceration, but nothing more. Yet, when by this collision forced to turn towards home, and for long months of days and weeks, Ahab and anguish lay stretched together in one hammock, rounding in mid winter that dreary, howling Patagonian Cape; then it was, that his torn body and gashed soul bled into one another; and so interfusing, made him mad.³² (p 200)

Ishmael begins with a negative probability ("It is not probable ...") that assumes its opposite even as it disavows. Indeed, some people might think it probable that Ahab became mad immediately upon his injury. But the reader is not allowed to escape into such comfortable feelings of misted distance and numbing difference—the obscuring fogs that permit the distribution of pity from divine heights. Instead, Melville forces an examination of the process through which it is likely that Ahab became mad. "Ahab and anguish lay stretched together in one hammock." A consubstantiation occurs over "long months of days and weeks" between his "torn body" and "gashed soul". The reader is forced to consider the precise nature of Ahab's suffering, to imagine the details and to confront her own physical vulnerability, fear and urge to flee into generalities, mysteries or abstractions. The comfortable opposition body/soul becomes a frightening amalgam fixed in a state of permanent anguish. The body drags the soul and the mind down with it. Like *Bartleby*, Ahab's injury is beyond our ability to cure. Once again the reader faces her limitation, her helpless vulnerability in the face of unreachable anguish—and it is intolerable. For the clinician this is a relatively common dilemma: the choice between staying connected to patients and their families, accompanying them step by step through suffering, or retreating to a more protected distance.

Melville underscores the fury in Ahab's madness and its pitiable nature: "He piled upon the whale's white hump the sum of all the general rage and hate felt by his whole race from Adam down; and then, as if his chest had been a mortar, he burst his hot heart's shell upon it" (p 200).³² The simile "chest like a mortar, the heart bursting like a shell" is moving but Melville counts on us to hear the "hell" in "shell". Reading then: "He burst his heart's [s]hell upon it". The misreading surprises the reader's identification with the magnitude of Ahab's suffering and the terminality of his state.

At this point in *Moby Dick* the reader shares the situation of a physician who feels hopeless and helpless in the face of so much suffering.

We return to *Bartleby* for the narrator's explication of the failure of pity in such incurable situations to see how Melville simultaneously heads off the reader's false insight and facile self-criticism (ie, confessing to a robbery in London to cover up a murder in Glasgow):

They err who would assert that invariably this is owing to the inherent selfishness of the human heart. It rather proceeds from a certain hopelessness of remedying excessive and organic ill. To a sensitive being, pity is not seldom pain. And when at last it is perceived that such pity cannot lead to effectual succor, common sense bids the soul be rid of it. What I saw that morning persuaded me that the scrivener was the victim of innate and incurable disorder. I might give alms to his body, but his body did not pain him—it was his soul that suffered, and his soul I could not reach.³³ (p 18)

"Common sense bids the soul be rid of it." Here is brutal reality presented in an imperative voice as if the narrator—even in stating his painful and shameful truth—could not bear to shoulder active responsibility for deciding to rid *himself* of the insufferable, suffering *Bartleby*. He emphasises the inevitability of the action from bid to rid with rhyme. The point is driven home with "... and his soul I could not reach". By ending with "reach", Melville uses the order of words in the clause to leave the reader aching for what we've already been told we cannot grasp.

But, what happened? How did the narrator originally full of pity and caring come to this "deforming, paternalist, kind of [smothering] mothering, coating over and covering up"?³⁵ The narrator tells us that when illness is "excessive", irremediable hopelessness infects the witness and connection through pity becomes more painful since there is no longer hope of succor. Melville here uncovers the judgement at the core of the withdrawal of pity—"excessive". Yet *Bartleby* is passive. He reacts more than acts. The narrator and the reader experience as coming from *Bartleby* wishes and demands that are the narrator's and reader's own projections. We require gratification from *Bartleby* that he cannot provide. We demand responsiveness, fulfilment of our own desire for relationship and connection.

So we cannot reach *Bartleby*, and his suffering burdens us and forces us to share in his immovability: this we cannot stand. Like the medical physician who hangs her sense of worth on the resolution of her patient's symptoms and, failing that, loses sight of the ways in which her need to prove her effectiveness creates the impossible demands she experiences as coming from the patient. But Melville, holding us close to *Bartleby*, has allowed us to begin to consider what might actually provide relief short of the magical restitution we want for/from him.

Aspects of both the "*Bartleby*" and the "*Ahab*" stalemates can be seen in the following excerpt from a research interview in which "Louise", a woman with breast cancer, talks about a pain crisis that turned out to be the onset of metastatic disease. She describes the events that led her to claim that she "fired" the physician who had been with her since diagnosis:

I couldn't get through to anybody—my nurse practitioner, my nurse, the doc. His secretary was screening his calls heavily. When I finally went to see him, he was the stereotypical cool, rational, white male and I was the crazy, emotional, hormonal woman—I was crying the whole time. He said, "I'm always available to you". The implicit message was, "Don't call me. Don't call me on the pager. Don't call my secretary. If you do call my secretary, she'll screen you out and say: 'Do you really need to see him? He's really busy'." Well, being the dramatic woman

that I am, I reached down into my bag and pulled out a cheese grater and a wooden spoon. I said, “*This is what my hip feels like*”. And I went like this. There were little wood shavings all over his office. His eyes got really big and he said, “Maybe you should see another doctor”. And I said, “Maybe I should”. So I fired him. So I didn’t have a doc, I didn’t have a drug, and I had bad hip pain. It was horrible.

In turmoil because of her fear (recognition) that her cancer had become metastatic, she calls her physician on the eve of his vacation. Even though she gets an appointment, she is angry and disappointed that he hasn’t responded in the way she would have liked. She complains that he was “cool, rational” and she was “crazy, emotional, hormonal—stereotypical”. In response he fires her (in spite of her claim to have fired him), indicating that he also feels out of control in the relationship. How did this caring physician become so suddenly overwhelmed that he fired a woman he’d treated for two years just as her disease has become metastatic?

It is not really the inappropriateness or magnitude of the patient’s demands that make him say, “Maybe you should get another doctor.” “Louise’s” cheese grater story acts on her physician in the way that Ahab’s transformation when he “and anguish lay stretched together in one hammock” brings Melville’s reader face to face with the problem of helplessness. Helplessness in this sense has two faces. One is Ahab’s, triggering the reader’s/physician’s intolerable awareness of vulnerability, an identification that triggers desperate efforts to repair the damaged other as a way to repair one’s own fantasy of invulnerability.

The other face is *Bartleby’s*. When we misunderstand the origins and objects of our frantic efforts, we see the damaged other as requiring us to fix them. Rather than sifting out our own needs for restitution from the patient’s needs, we project our needs to be powerful, knowledgeable and infallibly in control onto them. This makes it difficult when the patient does hope for an impossible cure for us to tell the truth about the limits of our ability. And if the patient has more realistic goals and desires, there is a tendency for practitioners to fail to hear them. Then when symptoms persist or disease progresses to the terminal phase, we may become exhausted, frustrated, hopeless and long to be rid of the whole situation. Surveys and interviews with physicians suggest that these largely unacknowledged feelings add to the sense of emotional burden that triggers the rupture of a relationship.^{3 13 16 30 34}

“Louise’s” physician has unrealistic expectations. His realistic sense of having disappointed her by not answering the pages and returning telephone calls becomes catastrophic for him because, irrationally, he takes responsibility for the progression of the disease and his inability to fix her. This loss of perspective sets the physician on a hamster wheel. Expending more and more energy and time in an attempt to deny his inability to undo the situation, he thinks “Louise’s” needs are excessive and sets himself up to experience global failure in response to painful but forgivable lapses in the relationship. He then becomes less able to face her death and his grief.

The nature of the impasse in this relationship stands out even more when we hear the patient’s story about her relationship with her next, and final, oncologist. On her first visit she told this new physician that he could “get with the program or get out”. And he—not put off by the confrontation and having as yet no assumptions about her expectations—responded, “What’s the program?” The new physician is unburdened by the remnants of a 2-year relationship with its failure to cure.

Unburdened, he can also watch over the death of this patient. He is free to find the middle ground in this first meeting—the ground Melville brought us to as readers when he held us in connection with his madmen.

When we know the details of each patient’s suffering we may begin to feel exhausted, helpless and overwhelmed. After all, “how can any one person hold that in his being and do it day after day after day?” It may be that understanding our own unrealistic demands for ourselves in the face of our patients’ suffering may not always be enough. It may be that services like hospice and palliative care, in which the day-to-day management of symptoms falls to a new team of providers, are essential to patients and physicians alike by allowing the long-term physician to disengage from responsibility for symptom control and focus on continuing the supportive relationship with the patient.

Hélène Cixous suggests we change our moral landscape to one in which “... the supreme value is pitilessness, but a pitilessness full of respect.”³⁵ (p 13) In other words, if there can be no pity without risking disengagement, if we who witness enduring suffering cannot overcome our pity and the resulting helplessness and fury at the failure of our efforts, perhaps we can find instead mutual respect for our shared, imperfect, terrifying, vulnerable, embodied state, a way to preserve our small, human-scaled grandeur that acknowledges our limited capacities so we do not abandon one another in catastrophic times.

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