



Into the Heart of Suffering: Lessons from the Story of the Tigress

by Bill Crane

In “Into the Heart of Suffering: Lessons From the Story of the Tigress,” Bill Crane uses a well-known jataka tale to reflect on the central role that mutuality plays in his work as a hospital chaplain. Weaving together vignettes of patient encounters and images from the Story of the Tigress, he offers a glimpse into how his relationship with suffering has deepened and evolved.

In a well-known jataka tale, the Buddha, as a bodhisattva in a previous lifetime, is said to have looked down from the edge of a cliff to see a starving tigress and her cubs. Gazing at the tigress’s “sunken eyes” and “emaciated belly,” along with how she brawled at her cubs “as if they were strange to her,” the Buddha realized that she would soon need to eat her cubs to survive.

According to one telling of this story, seeing the tigress caused the Buddha to be shaken with compassion, and he thought to himself, “This body is a constant source of suffering, and the wise man rejoices at expending his body for the benefit of another. Therefore, I will cast myself down into the precipice, and with my body I will save the tigress from killing her young ones and likewise save the young ones from being devoured by their mother.” The Buddha then gave

his life to save the tiger cubs and ease the suffering of the hungry tigress.¹

This story is sometimes told to illustrate the unfathomable compassion of the Buddha. But a more nuanced understanding (suggested to me several years ago by Lama Liz Monson) may be that it was in fact the Buddha's great fortune to come upon the hungry tigress, as the tigress provided an opportunity for him to ease the suffering of others.

Buddhist teachings are never meant to be swallowed whole but rather to be carefully considered in light of our lived experiences. My work as a hospital chaplain seems like a good place from which to consider the validity of this teaching.

Prior to doing chaplaincy work, I visited palliative care patients as a volunteer at Mass General Hospital in Boston. I was struck by the prevalence of suffering—so many patients faced serious illness and, in some cases, the hovering likelihood of death. But I also witnessed vast amounts of additional psychological suffering layered atop the physical—what Buddhist teachings term the second arrow.² Attached to previous conditions of good health, many patients and families resisted the reality of their illness, wanting (sometimes desperately) things to be different than they were.

Now, as a chaplain at Boston Medical Center (BMC), another large, acute-care hospital, I notice similar dynamics of suffering at work. As with most hospitals, the suffering at BMC has only been heightened by the pandemic, particularly last spring when, at times, the number of COVID patients exceeded 230. As BMC is an inner-city, safety net hospital, accepting patients regardless of their ability to pay, the suffering is often further compounded along lines of race and class, as patients may be struggling not only with illness but also with homelessness, incarceration, addiction, language barriers, or histories of trauma and violence. What's more, for two of the three days a week that I work at BMC, I am embedded in the palliative care team, which means that most

of the patients I visit will likely die relatively soon or may, at times, be in substantial physical pain.

The Story of the Tigress prompts me to ask: Why would I choose to put myself into this situation, particularly when I could just as easily have continued working as an attorney in a job that I enjoyed, or simply retired from work altogether? Is working at BMC, a place where I come face to face with so much suffering and death on a daily basis, actually my good fortune? Perhaps the best way to consider these questions is through the stories of a few of my patients.

David,³ a homeless man, had been sexually abused as a child. Haunted by traumatic memories, he turned to alcohol as his primary way of coping. Drinking wrecked his marriage and his ability to work, and he spent much of his adult life living on the streets, estranged from his family. He often landed in the hospital from alcohol-related medical complications and, occasionally, from violence he faced on the street.

I got to know David during a series of hospitalizations over the course of several years. He was one of the toughest people I have ever known, never asking for sympathy and never complaining. Over time, he let me in, sharing his life story, his concerns, and his hopes. I came to understand the suffering in his life but also to appreciate the independence that he valued, living life on his terms.

David shared with me how important our visits were to him, not because I offered any words of comfort or advice or even hope, but simply because he found in me someone who would listen without judgment—he said he had no one else in his life who would do this for him. From my perspective, what I offered David was simply my presence.

In my experience, presence is naturally strengthened through Buddhist meditation practice. During meditation, I seek to observe what arises in the mind in an open and relaxed manner. I do not seek to change or judge or anticipate the experience, but rather to carefully accompany it, letting it unfold on its terms. In this way, meditation becomes an

intimate process of opening to myself, just as I am, and every day, through this practice, I continue to learn the art of being as fully present as possible.

I apply these same principles to chaplaincy visits. When I walk into a patient's room, I seek to let go of any expectations or assumptions as to what I might find or how I might be helpful—even if I have visited the patient many times before—so that I may be as responsive as possible to what is actually occurring at that particular moment. I seek to be fully open and present to whatever the patient or family member is experiencing so that they will feel heard and seen (and accompanied) without judgment. Presence, for me as a hospital chaplain, is “ideally [an] opening of the heart that is genuinely receptive to the pain and suffering of others.”⁴ This is what I sought to bring to my visits with David and to my visits with other patients and family members.

When David realized that he was approaching death, our time together became more intense. Near the end of our visits, I would say a prayer as he held my hands tightly, and then we would look into each other's eyes. He shared with me that he was not afraid to die—I wondered if this was because of how close he was to death living on the street each day, or perhaps because of how much he had already suffered. Close to the end of his life, he told me he loved me, which I understood simply as a reflection of a deeply felt, personal connection between us; I replied that I also loved him.

As with so many other hospital patients I have known, there was a rich mutuality to my relationship with David. I would accompany him, helping him to get through a difficult hospital stay. And he would touch me with his life story, his suffering and his humanity. I deeply value the opportunity I had to know him, to gain his trust, and to be appreciated by him during the last several years of his life. He enriched my life with his life. Shortly before he died, I told him that I would never forget him, and I doubt I ever will.

Most patients and family members whom I visit, such as David, have some form of spiritual belief, and at BMC, many feel a close, personal connection with God (however the term “God” may be defined). When confronted with serious illness or when near death, BMC patients and their loved ones will almost inevitably look to their faith and turn towards God. An essential role of a chaplain, therefore, is to support the patient’s or family member’s faith through prayer.

I have found that for a prayer to be meaningful to a patient, it must also be meaningful to me. To make prayer meaningful, then, I have had to find language that works across faith traditions—most patients in my hospital are Christian; I am not. My own theology draws from Buddhist teachings that position our essential (or Buddha) nature as something ineffable that permeates each of us completely and equally—our common ground of being. All sentient beings are born out of—and die back into—this ground of being.⁵

Some Christian theologians, most notably Paul Tillich, have used similar language, referring to God as the divine “ground of all being.” Tillich speaks of God as “the name of this inexhaustible depth and ground of all being,” “the power of being in which everything participates,” and, most frequently, “being itself.”⁶ This apparent overlap with my theology has encouraged me to use the word “God” in prayers with patients of other faiths to reflect a mysterious, unknowable ground of being that is the source of all life and all healing, and that is common to each of us.

As a chaplain, my prayers function not as a vehicle to petition God to intervene (I don’t believe in a personal God or a God that intervenes in our lives), but rather as a way of helping the patient to feel closer to God—perhaps even to feel God’s presence and God’s love so that God may accompany them through the darkness of their illness. Prayer can be tailored to the particular patient or family member, taking into account their faith and relationship to God, as well as their emotional and spiritual needs. For some, I have found

that the experience of prayer can be deepened and enriched by adding guided meditation or visualization adapted from Buddhist practices.⁷ If a patient is very sick or approaching death, and if the patient already has a close relationship with God, then it is often prayer, more than anything else I might offer, that is most comforting and most valued, both to the patient and to their loved ones.

This was true for Carol. During my visits with Carol, we both knew that her life would be ending soon, likely within several weeks. She made it clear to me that it was not helpful to her to talk about her concerns about her impending death. Instead, we spoke about our lives, and in this way she sought to normalize our conversations and relationship. She told me about her previous work, her family, how she likes to spend her time; she asked about my family and how I spend my time. As our relationship deepened, I became comfortable talking with her about what might happen during the last few days of her life as her body began to shut down, encouraging her to trust her body at that time. We also enjoyed simply sitting together in silence, occasionally gazing into each other's eyes for a period of time.

Because I knew that Carol had a close relationship with God, I invited her to tell me about her faith as it related to her imminent death. She said that it was God (and not her) who was in charge. She accepted the doctors' conclusions that she would die soon but ultimately believed that this was God's plan—that God had given her this amount of time to be alive. I feel certain that she would have liked to live much longer, to spend more time with her family and to watch her beloved grandchild grow up, and yet she seemed to accept her fate—she trusted God's will. I believe that it was Carol's relationship to God, more than anything else, that helped soften her anxiety and diminish her resistance to her inevitable death.

As Carol moved closer to death, prayer became more and more important to her. I'd often begin with a few minutes of guided meditation to encourage both of us to relax and

become more present and open. I'd then move into prayer, including references to Carol, perhaps her illness, her likely death, her strong faith, and her family, especially her beloved grandchild. I might then spend some time recognizing God's presence with and within us and encouraging Carol to be open to this presence. We might spend ten minutes or so visualizing God's love shining down upon Carol, immersing her in vast, boundless, unconditional love. To end the prayer, I would often offer a short loving-kindness blessing, bathing Carol in wishes for happiness, peace and freedom from suffering. We would then open our eyes and simply sit together in silence for a period of time. Carol would often smile broadly; I would feel her happiness, her joy, her peace.⁸

There was something transformative about my time with Carol. With Carol (and many other patients) the presence of impending death brought us closer together, as the many differences between us—age, race, gender, economic status, and even faith—seemed simply to evaporate. As we prayed together, or even as we sat quietly together, it felt as though we found common ground, simply as two human beings.

When I visited Carol for the last time before she went home to die, we expressed our appreciation for each other. She shared that she would like me to think of her as my middle daughter (she remembered that her age falls between my two daughters' ages); I was deeply moved. Knowing that Carol would die soon, I sensed my own sadness, though I also felt inspired by her faith and deeply grateful that she and I had known each other.

Many patients are able to leave the hospital as death approaches so that they can die at home, like Carol, surrounded by their loved ones. This is often the best outcome for patients and their caretakers. But it's not always an option—many patients die at BMC. Countless times I have been present with patients at the moment of their death or in the minutes that follow. Most of my visits with COVID patients, for instance, have been at or very close to the end of

their lives. Being with death as it happens or just after it occurs is likely the most profound and sometimes the most challenging part of my work, all the more so in cases of fetal demise.

Angelina had just lost her baby at 19 weeks of pregnancy. When I entered her room, she was lying on the bed, her head propped up by pillows, with the fetus lying beside her. I sat in a chair next to Angelina. The fetus between us became a powerful focus of our attention—death and loss were with us in a concrete way.

A deep, quiet sadness pervaded the room. I sat silently with Angelina for a few moments before asking how she was doing. She began to speak softly, slowly at first, sharing her loss. There was not much I could say that would be helpful in that moment—mostly, I needed simply to be still, to give her space to tell me whatever she would like to say, and to remain open to what she was experiencing. Through my stillness and presence, I sought to help her hold her immense grief.

As she spoke, it became apparent that Angelina was a person of strong faith. She had a meaningful relationship with God, and the depth of her suffering seemed to allow her to feel closer to God. And so we prayed together, seeking God's presence and unconditional love to be manifest within Angelina and to help her begin to heal from her loss. I then provided a blessing for the fetus, praying that he may feel embraced and held in God's vast, unbounded love so that he will have true peace this day and forevermore.

Saying goodbye and leaving the room, I felt a strong sense of connection with Angelina—something profound had passed between us. I sensed her appreciation for the visit. But I also felt a deep sense of privilege to have a job that provided me an opportunity to know her even briefly, to feel her suffering and to accompany her in prayer. She, like the tigress, offered an occasion for me to lean into the compassion that arises naturally in the midst of sadness and

grief, and through entering into her loss together, we arrived at a moment of shared intimacy and understanding.

Sometimes, though, death brings grief that feels overwhelming, grief that gives way less easily to shared connection and common ground. One night, when I was working as the on-call chaplain, a page came in from the Emergency Department. Grace, a teenager, had been found unconscious in the community—an apparent victim of a suicide attempt. She was brought into the hospital, where the emergency services doctors and nurses were unable to resuscitate her.

I made my way to the trauma bay where Grace was lying on a stretcher in the middle of the room with a social worker and nurse nearby. Medical debris was strewn across the floor, artifacts of the unsuccessful fight to save her life. I spent a few quiet moments next to Grace. All of the weariness inherent in living had left her. I felt Grace's presence which seemed to ground me, and a sense of calm—almost peace—in the room.

The social worker offered to take me to a nearby waiting room and introduce me to Grace's family. I accepted, and we approached the room together. There, we were met by many members of the family, gathered together, but Grace's mother, Marie, was by herself. Crouching on the floor, she was making loud noises beyond description, filled with extraordinary grief. I had never experienced another person suffering so much. I sat down on the floor beside her and introduced myself; I touched her shoulder lightly; I tried to accompany her as best I could, so that she would not feel alone in the hurricane of the sadness that engulfed her.

When the family was ready to visit Grace, we slowly made our way to the trauma bay. Marie became calmer as we walked, but as soon as she saw her daughter, her grief intensified. She draped herself over Grace, overwhelmed by sadness. I positioned myself beside the two of them and, when it seemed appropriate, said a prayer.

After fifteen minutes or so, we had to find a way to help Marie leave her daughter in order to free up the trauma bay for another patient. Marie was simply unable, emotionally, to leave on her own. After a few failed attempts, a physician firmly told Marie that she needed to leave her daughter because she would not want to remember Grace in this way. We found a wheelchair for Marie, who was now willing to leave but so distraught that she couldn't walk. All together, we maneuvered our way slowly back to the family waiting area. Then, after a while, the family was ready to leave for home, except for Marie who said that her daughter needed her to be at the hospital. Eventually she relented, and I accompanied the family to their cars and said goodbye to Marie, who said nothing to me—we had spoken only a few words during our time together.

I have often found myself reflecting on my time with Marie. I don't know whether I was of any help to her, but in light of the intensity of her suffering, I am grateful to have been in a position to offer her whatever I had that could possibly comfort her. I believe that was my presence. I did not try to take away her suffering, nor did I try to take on her suffering as my own (this would be unbearable); rather, I simply stayed physically close to Marie, and tried to remain receptive and open, as much as I could, to her suffering, and to accompany her in this way.

Some of the most intense emotional pain that I experience at BMC is when a parent, such as Marie, unexpectedly loses a relatively young child. Marie's suffering overwhelmed any ability that I might have to let her grief simply pass through me, with the result that a part of the suffering has lingered within me, still moving through my memory bank. Over time, the memory softens and is more easily held, but still it remains.

Several years ago, when I heard Lama Liz Monson explain that we might understand the Story of the Tigress as revealing the Buddha's good fortune of coming upon the suffering tigress and her cubs, her insight intuitively

resonated with me. Reflecting further on the story now, I consider more carefully both the burden of opening myself to extensive suffering in the hospital and the benefits and rewards from doing so.

Sometimes a patient's or family member's sadness can be searing and stays with me, as with Marie, and opening to their suffering can feel like almost too much to bear. And when I allow myself to relax after finishing a full shift at the hospital, which usually lasts about ten hours, I often feel within me the weight of the day's sadness. By the time I arrive home, I am emotionally and physically weary, sometimes exhausted. At times, I've feared that I might be burning out from compassion fatigue. My capacity to open myself to suffering has expanded over time but always has its limits, and I must find ways, on a regular basis, to reduce the stress that naturally accumulates in the body.

As a consequence, the suffering in the hospital can, at times, feel to me like a burden. But, perhaps paradoxically, it is this same suffering that creates the conditions that make my job uniquely rewarding: it is often the pain of patients and family members that causes them to share with me their life stories, and their hopes, vulnerabilities, and fears. It is because of their suffering that a prayer can feel deeply meaningful not just for a patient or family member but for me as well.

Most importantly, opening to the suffering of others brings with it the opportunity to connect with their humanity. When someone becomes very sick or when death is near, the exterior differences that often separate us (including our age, race, gender, and role as patient or chaplain) tend to fade into the background. This may allow for a more intimate, human connection—a connection with little, if any, separation between us. I believe this is why the relationships that have developed within the context of a patient's or family member's suffering are so meaningful to me. Perhaps these human connections are also what patients and family members who are deeply suffering need most.

Finally, as a chaplain, I have the good fortune of spending time with patients who are close to death; they have much to teach me. These patients help me to understand and accept the inevitability and unpredictability of my own death. I have learned that death may arrive at any time or place, with or without warning, and to a person of any age or circumstance. Feeling close to death, through the patients I visit, helps me to appreciate life. To be alive, I am reminded, is an extraordinary, fleeting gift that should never be wasted or taken for granted.⁹

Reflecting on the lessons of the Story of the Tigress, I am mindful of the challenges of opening myself to the suffering of others. But having the opportunity to spend time with those who are suffering, I have found, is deeply meaningful, making my life richer and more complete. Being a chaplain at BMC is, indeed, my good fortune. It seems ironic that my Buddhist practices of these past 35 years have emphasized a path intended to lead to the end of suffering, and yet what I have found to be most rewarding leads me right into the heart of suffering—perhaps it is helpful to go through suffering, spending time in its deepest depths, to find its end.

¹ Venerable Āryaśūra, “The Story of the Tigress (Dāna),” in *Jātakamālā: Garland of Birth Stories*, translated by J. S. Speyer (Oxford: Oxford University Press, 1895), 3–12.

² The teaching states, in part: “When touched with a feeling of pain, the uninstructed run-of-the-mill person sorrows, grieves, and laments, beats his breast, becomes distraught. So he feels two pains, physical and mental. Just as if they were to shoot a man with an arrow and, right afterward, were to shoot him with another one, so that he would feel the pains of two arrows; in the same way, when touched with a feeling of pain, the uninstructed run-of-the-mill person sorrows, grieves, and laments, beats his breast, becomes distraught. So he feels two pains, physical and mental.” For the full sutta, see Thanissaro Bhikkhu, trans., “Sallatha Sutta: The Arrow” (SN 36.6), *Access to Insight (BCBS Edition)*, November 30, 2013.

³ All patient and family names and identifying characteristics have been altered in order to protect the privacy of patients and their families.

⁴ Bhikkhu Anālayo, *Compassion and Emptiness in Early Buddhist Meditation* (Cambridge: Windhorse Publications, 2015), 7.

⁵ Consider the analogy, sometimes used in Buddhist teaching, of waves and an ocean. Each wave is born out of and dies back into the ocean. Each wave has its own unique form and appears to be a separate entity, but each wave's essential nature is the common ground of the ocean.

⁶ Paul Tillich, *The Shaking of the Foundations* (New York: Charles Scribner's Sons, 1948), as quoted in Martin Luther King, Jr., "A Comparison of the Conceptions of God in the Thinking of Paul Tillich and Henry Nelson Wieman," in *The Papers of Martin Luther King, Jr. Volume II: Rediscovering Precious Values, July 1951–November 1955*, ed. Clayborne Carson et al. (Berkeley, CA: University of California Press, 1994). For further synergies between Tillich's work and Buddhist thought, see Ellen Y. Zhang, "When the Ground of Being Encounters Emptiness: Tillich and Buddhism," in *Paul Tillich and Asian Religions*, ed. Keith Chan Ka-fu and William Ng Yau-nang (Berlin; Boston: De Gruyter, 2017), 87–108.

⁷ For example, visualizing the Buddha of loving-kindness sending unconditional love to us can be easily adapted and incorporated into prayer for persons of other faiths. See Tulku Thondup, *The Healing Power of Loving-Kindness: A Guided Buddhist Meditation* (Boulder: Shambhala Publications, 2009).

⁸ Buddhist teachings point to unique opportunities for spiritual practice near the time of death. For instance, an early Buddhist discourse "highlights the potential of the time of approaching death in leading to a degree of liberation that earlier would not have been possible." A sick lay disciple may be supported with "guided meditation ... through a step-by-step diminishing of attachments lead[ing] onwards to ever more refined types of happiness"; Bhikkhu Anālayo, *Mindfully Facing Disease and Death* (Cambridge: Windhorse Publications, 2016), 156–57.

⁹ Buddhist scholars have emphasized the importance of death awareness. See, for instance, Bhikkhu Bodhi, ed. and trans., *In the Buddha's Words: An Anthology of Discourses from the Pali Canon* (Somerville, MA: Wisdom Publications, 2005): "The realization that we are bound to grow old and die breaks the spell of infatuation cast over us by sensual pleasures, wealth, and power [and] motivates us to take fresh stock of our purposes in life" (20). See also Bhikkhu Anālayo, *A Meditator's Life of the Buddha: Based on the Early Discourses* (Cambridge: Windhorse Publications, 2017): "Mindfulness of death has an immense transformative potential and can become a powerful mode of progressing towards the deathless, towards going completely beyond being affected by death through the full realization of Nirvana" (155).