Double Vision

John Brewer Eberly Jr, MD

Anderson, SC

“That little shiver of pleasure-horror that goes through your spine when you read about someone else’s suffering, that quick metaphysical incision like a bone marrow biopsy of the soul: it’s for yourself. … There’s nothing wrong with this—it’s one of the functions of literature to wake one up—but if you mistake this reaction for action; if you confuse this shadow sympathy for the kind of real feeling that operates in the world with risk and agency … if you mistake love of literature for love—well, dear reader, read on, read on.” — Christian Wiman

Ms J was in the ED with double vision. As I entered her room, I felt the familiar tension between the active task of the workup and the reactive task of the writeup: how I might diagnose her complaint and capture her story. As she explained again her symptoms, it began:

Listening to her, I thought about the genre of pathography: inhabiting the perspective of another’s illness. Could I capture the suffering of someone so different from me, lending voice to the experience of an elderly woman lying confused in a hospital bed? Or is that not the very definition of appropriation?

Caught up in my head with this thought, I shake myself back to reality. Some struggle with “turning off” being a doctor at home, but that comes easy for me. The voices of my sons make it so, drawing me back (“point your face at me, Daddy”).

What I struggle with is something more insidious: tempering love of art while doctoring. Just as there is a temptation to answer MyChart messages between Lego bricks, I find there is a constant temptation to sketch stories, essays, and poems between patients. It’s difficult to practice good medicine with that kind of ever-present distraction, when each patient is beholden to potential publication, and quote-mining threatens every bedside.

As I reckon explicitly with this duplicity, I find it intractable.

And so I pay attention to the patient’s words. Ms J is asking me, “What are you thinking? What do you see?” Surely there is something to be explored there, some deeper meaning. Those are more than earnest words from a concerned patient.

Perhaps I could just write about the teaching moment. I could sketch a lesson to our medical student about double vision. It would aim for a crescendo of pithy wisdom, but, of course, the end would be subversive. We would find that, all along, the medical student had been teaching me and the patient teaching both of us. I could write of this parallel posture of medical education and the importance of giving and receiving the gifts of unsevered attention.

But there remains Ms J in front of me who needs my full attention now. For years, I have struggled to attend with this unity of thought. As Jon Foreman sings, quoting Kierkegaard, “purity of heart is to will one thing … but I’ve got a lot on my mind.” Where is the singularity of focus that Ms J so deserves?

To imagine future writing while practicing is to engage in a kind of pyramidal decussation of human experience, where what I feel and what I do cross back and forth like edge lines cut cold in the ice by the blades of the skater. They suggest not only beauty and movement and harmony but also the risk of concussion. I suspect each of us who struggle to bring narrative balance to the undulations of medicine experience this tension. As we struggle to both see our patients clearly and find meaning, we skate close to voyeurism.

At its worst, this kind of dualism may shut down clear meaning. The mind divorced can exacerbate the instrumentalization of the medical humanities, in which the stories and poetry and artwork that we celebrate act as merely discrete interpretive “overlays” for the body-reduced-to-machine, where purpose ultimately submits to function: What will you do? And I don’t know what to do here. Ms J is complaining of polyarticular arthralgias and a transient rash. Perhaps now I might describe this as the “interesting case”; the story passed through the prism of clinical problem-solving. I could write about zebras in such a way that we neither hear hoof beats nor see stripes but simply...
wait to be put in the path of the once-in-a-lifetime meteor, radiant in the darkness.

And what about that darkness? The confusion I see in her face that causes me sorrow. It is exacting to be present to another’s pain, let alone share it through art. But isn’t this how catharsis happens?

Or am I perpetuating Ms J’s suffering by trying to write about it, trapping her in words? How do I avoid the reality that I am, by this very sentence, strangely profiting from her pain? Even when there is no publication, no tweet or book deal, even when the details are changed to protect the patient’s identity, does not the catharsis draw a kind of credit from the life of this patient without her consent? I took the Hippocratic Oath, but David Schiedermayer’s “Corporate Oath” seems more fitting:

“Things which I may see or hear in the course of treatment, or even outside of treatment regarding the life of human beings, things which one should never divulge outside, I will report to government commissions, immigration officials, hospital administrators, or use in my book.”

I recognize there must be an alternative where medical writing simply seeks to tell the truth with goodness and beauty by capturing reality at its fullest and thus aiming for a great justice on behalf of the patient. Flannery O’Conner called this “the analogical vision,” one that does not mistake “shadow sympathy” with love but rather recognizes that words carefully chosen can inspire us to moral action.

And so I thought about carefully chosen words. I could describe the strange reality that patients come to us enfleshed and we turn them back into words, “in flourish and arrogant crook,” as the poet Edwin Muir wrote. “And there the logical hook / On which the Mystery is impaled and bent / Into an ideological argument.” But what am I arguing again?

I am tempted to believe this is all navel-gazing and hand wringing and self-indulgence. Yet I know and believe that when we seek to clearly see (and even tell) our patients’ stories in good faith, we are truly doing the work of good medicine, in which imagination and creativity are part and parcel with the way of healing. As Wendell Berry writes, “If I live in my subject, then writing about it cannot ‘free’ me of it or ‘get it out of my system.’ When I am finished writing, I can only return to what I have been writing about.”

And as I am suddenly awakened to that work, here again, at the bedside of the sick, I can tell you I feel a pang of shame even as I hear the call to attend, again. And as my hands rest again on stethoscope and skin, I recognize reconciliation as I read her, my patient, and she reads me back, and through this double vision of literature and love we read on, read on.

References