As a young physician, I often struggle with how I am supposed to "see" my patients. History-taking, physical examination, diagnosis, and treatment: a physician tries to see patients with a dispassionate gaze, so that he or she can sort out the modest complaint from the life-threatening one.

Looking at patients dispassionately does not come naturally. You have to learn it, and the process can be a shock. I recall the first autopsy I witnessed during medical school. All rituals have their associated vestments, and for this one I "gowned"—put on scrubs and plastic apron, safety mask, latex gloves. Entering the dissecting room, I saw an elderly African-American man lying on a steel table, his hands by his sides. He looked kind and paternal, like a sleeping grandfather. Pink, puckered suture lines ran up each leg, where the man's hips had been replaced; his right foot was blackened and yellowed by diabetes; but his hair was well groomed, his face at ease, his hands open. He had died three hours earlier while waiting for a leg amputation.

The autopsy had all the solemnity of thieves stripping a car. As the resident pathologist greeted me warmly, her assistant moved silently about the body, opening the grandfather's chest with a long, deep incision from the top of the sternum to the break of the hips. Within five minutes, he was cutting open the grandfather's rib cage; within ten he was examining the organs. He tied off the bowels with kite string, making a long and convoluted sausage, which the resident untied in the sink, spilling out feces as she "ran the bowel," searching for occult disease. While up to her elbows in partially digested hospital food, the resident extolled the virtues of pathology as a medical specialty, encouraging me to consider its high-paying, low-hours glory. "And one thing about pathology patients," she joked. "They never miss an appointment."

Back at the table, the assistant placed lungs, kidneys, heart, and what remained of the gastrointestinal tract in a bowl. The resident then began slicing each organ as if it were a loaf of bread, all the time looking for pathology. The assistant, meanwhile, cut the grandfather's scalp from ear to ear, then opened the skull and drew out the brains for the resident's inspection. Finally, he rolled the flesh back into its original shape, toweled off some blood, and sealed up the body for the undertaker, who would arrive within the hour and begin the process of making the grandfather presentable to his kin. His work done, the assistant left, and the pathologist stood alone with a bucket of still-warm organs and one incredulous medical student.

I inquired if she was a vegetarian. No, she said; why did I ask? There was no use explaining that those human organs looked like fresh beef to me. As all physicians must, she had learned to see organs instead of a grandfather, to gaze with the eyes of a pathologist rather than those of a granddaughter, a neighbor, or a friend.

In The Birth of the Clinic, Michel Foucault writes that it was precisely by dissecting corpses that modern physicians learned to see their patients as collections of diseased organs. He describes the "great break in the history of Western medicine" as the moment, two hundred
years ago, when clinical experience became dependent on the "anatomical gaze," an intimate sense of how bodies are ordered and disordered beneath their skins. Foucault quotes Marie-Francois-Xavier Bichat, a physician reared in an older medicine-one not dependent on pathological anatomy-who complained in 1801 that years of bedside note-taking all too often left a physician facing "incoherent phenomena" that resisted accurate diagnosis. But "open up a few corpses," Bichat wrote, and "you will dissipate at once the darkness that observation alone could not dissipate."

And so the modern medical clinic depends on the cadaver in the anatomy suite, the corpse in the coroner's refrigerated offices. But Foucault insists that we misunderstand the nature of this dependence. While historians of medicine typically follow Bichat in regarding the advent of pathological anatomy as the critical moment in the development of modern medicine, they do not recognize, as Foucault points out, that the transformation was really epistemic: as physicians learned to "gaze" upon the bodies of the dead, a perceptual transformation occurred in medicine that incorporated death into medical discourse and practice.

In short, Foucault contends, modern physicians are pathologists. We all work backwards, from death to life. Once we learned to see like pathologists, disease was no longer a foreign attacker, but the body itself becoming ill. Nor was death still a single event, the moment when life ceases to animate the body. Rather, it was seen as an ongoing process located within the body itself, measuring the body's unalterable progress toward the grave.

From the end of the eighteenth century, Foucault believes, death became the very foundation of the modern medical understanding of life. Trained to acquire the clinical gaze, physicians can now look on disease and make clear and certain descriptions of it. But the irony, as Foucault observes, is that physicians are seduced by this clinical gaze, and fail to recognize the living, breathing patient before them. Thus, my resident pathologist mistook the grandfather she met in the morgue for a corpse.

As a Catholic, I am called to see patients with a different gaze, the compassionate gaze of faith. While still a medical student, I struggled to understand what difference faith ought to make in my career. Should I attend to the poor, as demanded in Matthew 25, by building hospitals for traveling strangers as St. Basil did, or bathing the wounds of a leper, like St. Francis? Should I emulate Dorothy Day and feed the hungry? My own abilities seemed ill suited to working in these ways. Furthermore, following Foucault, I began to suspect that to practice a different sort of medicine would require not just a commitment to social justice or faith-based programs, but a challenge to the very sort of clinical gaze that keeps us from seeing the patient as a unique person-and, in religious terms, as a member of the Body of Christ.

When I try to imagine a medicine guided by faith, I think of the French Jesuit theologian Pierre Rousselot. In The Eyes of Faith, Rousselot offers an incisive analogy. Two detectives are dispatched to a crime scene. Upon arrival, they inspect the scene together, and they notice the same detail. The first makes little of it. The second observes the detail but achieves certitude from it. Rousselot writes about seeing the crime scene with the "eyes of the law," the integrative vision that allows the second detective to grasp the detail as a clue and to solve the crime. While Rousselot admits the two detectives may have different sets
of knowledge, he insists that the crucial difference is how they employ that knowledge. Real understanding grasps a detail and sees it in the larger picture.

When a believer and an unbeliever survey the same scene—in this instance nature or creation—the believer comes away with a deeper, more certain faith, whereas the unbeliever departs in the same state as when she arrived. Just as the second detective sees with "the eyes of the law," the believer understands with lumen fidei, the eyes of faith. Catholics who practice contemporary medicine, whether as physicians, nurses, therapists, or aides, ought to approach their discipline with a distinctive awareness: the ability to recognize the patient, even in her illness, as a sign of God's gracious creation, one who evokes knowledge and love of God. For Rousselot, that is the mark of a saint. It is something I approach only occasionally.

Recently, I cared for a man in the emergency room. He was middle-aged and an alcoholic. A sour stench confirmed his claim that he lived in the woods and drank a fifth daily; his hair was clotted with blood. As he spat out demands, his partially chewed hospital food splattered my white coat. Disgusted, I retreated into the safety of professionalism. I admitted him and ordered an alcohol-detox protocol, but I offered him little else. Later I felt perplexed and even ashamed. I had examined the man carefully enough, ordered the appropriate tests, and made certain he got the indicated treatment; but I had missed him.

When my shift ended, I went home and read Matthew 25 again. At the end of his public ministry, Jesus enjoins his followers to practice the works of mercy, those quotidian acts of a first-century Jewish community: to tend to the hungry, the thirsty, and the naked; to visit the sick and the imprisoned. What distinguishes these acts in Matthew is their object. Jesus says that when the disciples perform them, their recipient is the Son of Man, and that when they fail to do these things, they fail to respond to him. Jesus enjoins his disciples to minister to the sick—not simply in order to keep a professional clinic or hospital going, but in order to reveal and deepen their relationship with him. That is, the Kingdom of God is revealed in their acts of compassion.

St. John Chrysostom, writing in the fourth century, observed that Jesus does not say to cure or to heal the sick, but simply to visit them. Here Matthew uses the word episkeptomai: to look upon or look after; to inspect with the eyes in order to see how one is; to help, benefit, or to provide for. But Matthew registers something further, for here episkeptomai also suggests a concern for the other's salvation. Jesus calls his disciples to look on the ill with what we might call an eschatological gaze. Furthermore, the Greek word asthein does not only mean "to be ill"; it can also mean "to be poor, weak, or powerless." Jesus calls his disciples to attend to the well-being of all those who are ill, poor, weak, or powerless; in so doing, he says, they attend to him.

This is the lumen fidei of which Rousselot wrote, which I still struggle to practice. Even as a medical student, I should have looked on that dead grandfather as a neighbor and a sign of Christ. As a physician, I should have recognized Christ in the bloodied alcoholic. While the clinical information that can be gained from interviewing a bloodied alcoholic may be minimal, seeing this particular man with the eyes of faith might have allowed me to understand him better. Yes, I had paperwork to finish, and an insistent pager to respond to. But a clinical encounter is more than just another case study for discussing on grand
rounds. It is an opportunity to be a witness to the ravages of illness. I had acted like the unseeing detective: I had not seen the man with the eyes of faith.

How does a physician learn to see a patient with both a clinical gaze—one that enables him to diagnose and to prescribe treatment—and with the eyes of faith? For one thing, I suspect that Christians cannot simply practice medicine as it is currently practiced, in a system geared to increase efficiency and quantifiable outcomes. The current medical model must be challenged by reintroducing a sense of compassion, and by reorienting medical practice toward the well-being of the whole person. Some of the best examples of the contemporary healing ministry in the church are communities like L’Arche, the Catholic Worker, the Hawthorne Dominicans, and the Medical Mission Sisters. These communities of faith are oriented to the ill and the dispossessed. They affirm the presence of Jesus and of his church.

Irrespective of professional training or vocation, we are all called to orient ourselves toward the Christ in our midst. That is why the church’s care for the ill has never been limited simply to providing medical treatment, but also includes welcoming the stranger; sheltering the vulnerable; shepherding the newborn into the world and the dying out of it; providing the Eucharist, absolution, and the anointing of the sick; resisting violence; and forming communities of disciples. To foster such a robust Christian health ministry is admittedly a daunting challenge. But, updating Dr. Bichat’s advice: Open up your heart this way and you may begin to see through the darkness that the clinical gaze alone can never dissipate.

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Commonweal 134.7 (Apr 6, 2007): 10-12,14.