(Re)Examining the Clinical Gaze Through the Prism of Literature

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The fact that physicians have the authority to direct a probing, dissecting, and analytic gaze toward their patients is one of the most unique, yet by and large unremarked upon, aspects of the doctor-patient relationship. Using the work of Michel Foucault as a foundation, as well as examples from fictional literature, this article raises the question of how we as clinicians look at our patients, how our patients gaze back, and what can be accomplished or destroyed by these exchanges. The article first revisits characteristics and consequences of various types of clinical gaze. It then suggests the importance of training the gaze to include "transformative" modes of seeing, such as empathically witnessing the suffering of patients and recognizing the common bonds we share with them, in order to restore a humanizing dimension to professional perception.

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Many professionals, including psychotherapists, teachers, pastors, and artists "gaze" upon others in both literal and metaphorical ways. But the practice of medicine ideally employs a clinical gaze simultaneously organized along analytic, diagnostic, empathic, and healing pathways not fully replicated by any other profession. Patients expect, permit, and even invite the physician's actual gaze to explore the exteriors and interiors of their bodies in exchange for explanation and relief of suffering (Klass, 1987). Physicians, in turn, use this literal gaze to inspect, analyze, assess, diagnose, as well as convey a range of emotional attitudes. But the clinical gaze as *metaphor* also symbolizes broader, more intangible dimensions of interaction and relationship in ways of great importance to both patient and doctor. When we ponder the clinical gaze in all its multi-dimensionality, we discover we are only in the beginning stages of comprehending what it is, what it might be, and how it should be trained.

Defining the clinical gaze. Medical education has treated the gaze either as an observational, data-gathering tool or as a nonverbal communication technique. On a content level, of course, all medical students are trained to become careful observers of patient signs and symptoms. This usually means honing one's analytic visual assessment of specific aspects of the patient's physical presentation. In

combination with other sources of data-gathering, the gaze-as-observation is a key component of the medical system of diagnosis, prognosis, and prescription.

On a behavioral level, we classify the clinical gaze under the category of "eye contact," a nonverbal behavior that is itself nested within the larger grouping of doctor-patient communication skills. Medical interviewing techniques emphasize the importance of making eye contact with patients (Coulehan & Block, 1997), while recognizing that this behavior should also be influenced by factors of duration, frequency, gender, and circumstance (Randall-David, 1989; Kleinke, 1986).

However, the clinical gaze is inevitably more than simple observation or eye contact. The essence of the clinical gaze has as much to do with the psychological and spiritual *meanings* it creates for both patient and physician as with the empirical evidence it adduces or its more quantifiable behavioral properties. The gaze is not simply a unilateral action directed by an actor (physician) toward a passive object (patient). Rather, it is a metaphor for an evolving relationship emerging conjointly from the personhood of the doctor and that of his or her patient. Indeed, the exchange of gazes helps to create, reflect, destabilize, and reconstitute this relationship. Of course, literally speaking, it is not "the gaze" that communicates, but the persons doing the gazing. Nevertheless, reflecting on the gaze rather than on the people gazing can be useful. By thinking about *how we look* at the Other, and how the Other *looks back* at us, we can learn something about *who we are* in relation to each other.

Training the clinical gaze. While few medical lectures are provided on training the clinical gaze as the term is used in this paper, much subtext about the gaze exists. William Osler (1987) implied that physicians should gaze on their patients with "aequanimitas." Many physicians continue to believe that the detached clinical gaze is essential for the application of proper science to the patient (Landau, 1993). On the other hand, it has been pointed out that "if the physician's gaze loses sight of the patient's immanent humanity, it is the patient who suffers..." (Henderson, 2000). We must therefore wonder in what manner the gaze should be conducted. Should we look at the patient with steadiness or tenderness, or some admixture thereof (Coulehan, 1995)? What is our intent when we cast our gaze in the direction of a patient? And what is the meaning of the gaze we receive in return?

FOUCAULT HELPS US SEE THE CLINICAL GAZE

Becoming aware of the gaze. Michel Foucault, the French post-structuralist philosopher who viewed himself as an "archeologist" of social patterns, was among the first to call attention to the physician's gaze as instigating and creating a new kind of relationship between doctor and patient. In *The Birth of the Clinic* (Foucault, 1973), Foucault documented the rise during the eighteenth century of "*le regard*," the detached, scientific, objectifying professional gaze. This gaze was in large part the result of the newly emerging science of pathological anatomy, which for the first time enabled doctors to penetrate the surface of the (dead) body (Scott, 1987), in the process transforming the (living) patient's bed into a field of scientific investigation. Foucault contrasted the scientific gaze with the subjective, surface gaze of earlier generations of physicians, which was necessarily less expert but more humane.

Properties of the clinical gaze according to Foucault. Foucault's analysis highlighted the inherent power of the clinical gaze, which he described as "the depositary and source of clarity...[with] the power to bring truth to light." This new gaze presumed to penetrate below the surface

of things–and people–until it became "the master and determiner of truth," able to distinguish between the appearance of truth and truth itself (Riska, 2000). By implication, whatever this gaze could not detect or understand necessarily fell outside the domain of important knowledge. Because of this property, the gaze became the primary vehicle by which not only physicians, but also the patients themselves, discovered what was "real" and objective about their symptoms and what was subjective and therefore invalid. Doctors alone, through their gaze, had the competence to make proper judgments about health and illness (Malterud, 1999). The gaze was dominating and governing, with both decisional and interventional authority, the power to determine "how things really are."

Above all, the gaze identified by Foucault was a modernist one in which an expert imbued with professional knowledge used a visualizing modality to gather specialized information about the patient beyond that which the patient him or herself could provide. One of the attractions of the clinical gaze (later to be complemented by "technological" means of gazing, such as x-rays, MRIs, CAT scans, and laboratory testing) was that it enabled the physician to pass more quickly through the discursive, subjective, and often unreliable patient narrative. By giving the physician an expert way of gathering data inaccessible to the patient, the physician gained a new sense of control and invulnerability.

Effects of the Foucauldian gaze on patients. While the clinical gaze Foucault specified had the power to diagnose pathology more accurately and efficiently than previous approaches, it could also become a form of social control, urging its targets (patients) into a posture of self-surveillance (monitoring for disease and pathology) and confession (willingness to relinquish personal privacy). Yet the ends and purposes of these behavioral controls were sometimes defined more by the medical community than by patients themselves (Pryce, 2000). The gaze dissected, segmented, and disassembled people without containing a process for restoring their wholeness. Thus, the gaze tended to jeopardize the patient's claim to authenticity. What the patient "really" felt, even who the patient "really" was, became dependent not on his or her own subjective experience, but on what the gaze discovered and concluded. In this model, the individual increasingly became an object to be broken down and explored, a disembodied collection of organs or pathologies. The effect of the gaze was to turn the patient into the Other, someone (or something) completely different and separate from the examiner. At its worst, the gaze evolved into a form of symbolic violence against patients, a powering-over that reduced and demeaned their humanity (Bourdieu, 1991).

GAZING AT THE GAZE THROUGH LITERATURE

Invaluable though Foucault's contributions were in first making us aware of the existence of the gaze, and then helping us to question its purposes and effects, his writing focused only on one permutation of the phenomenon. Of course, other forms of the gaze exist, some more dangerous and some more humanizing than the one Foucault uncovered. Further, Foucault did not emphasize the *patient's* gaze because he was more interested in the effects of the power wielded through the *physician's* gaze on patterns of social discourse. Indeed, Foucault claimed that "medicine is all about the confrontation of a gaze and a face… in which people are trapped in a common, but *non-reciprocal* situation (italics mine)." However, the patient is more than a "docile, compliant body" (Pryce, 2000), the passive recipient of the medical gaze. Patients can also turn their gaze on doctors (Szykiersky & Raviv, 1995), and power flows from as well

as toward patients (Williams & Calnan, 2000).

To further our understanding of the clinical gaze, we must do some archeological digging of our own. One "artifact" that can be helpful in this excavation is fictional literature about doctors and patients. The evocative, imaginative qualities of literature allow us to easily comprehend, be moved by, and reflect on different aspects of the gaze. Literature is effective in this pursuit because its assumptions and interests focus on issues of meaning and relationship, thereby providing useful, immediate access to the multiple dimensions and possibilities of the gaze. While generally the medical literature has not paid much attention to the clinical gaze,[1] in fictional literature, references to the gaze linking doctors and patients are common. We will examine several aspects of the gaze-in-literature, including non-Foucauldian, Foucauldian, and post-Foucauldian interpretations.

THE ORDINARY GAZE VS. THE SCIENTIFIC GAZE

The ordinary gaze. Philosophers of medicine have sometimes distinguished between the scientific and the ordinary gaze. While the scientific way of perceiving reality has been criticized for its dehumanizing tendencies, ordinary patterns of perception have been praised as full of possibility and promise if reincorporated into the doctor-patient relationship (Hick, 1999). Yet most of us who have directed an ordinary gaze toward patients, or received such a gaze in return, are aware that it too can sometimes cause harm because of its lack of reflexive awareness and intentionality. Within the framework of the clinical encounter, several literary examples of problematic "ordinary" and "scientific" gazes are discussed below.

The voyeuristic gaze. The voyeuristic gaze has as its aim not the assistance of the patient or the amelioration of the patient's suffering, but rather gratification of the physician's curiosity and cravings, and perhaps reassurance of his or her own anxiety (Kendrick & Costello, 2000). It is an overly intimate, self-indulgent gaze, springing from a desire to move too close to the patient in fulfillment of physician desires. At first glance, the gaze of voyeurism seems remote from the practice of medicine. Yet it is a gaze that sometimes infiltrates the attitudes of medical students in a gross anatomy lab, or at the bedside of a patient with an obscure, but intriguing medical condition. And how many physicians can claim never to have gazed at a patient with voyeuristic fascination?

Bernard Pomerance's play *The Elephant Man* (Pomerance, 1973) tells the story of the 19th century historical personage John Merrick, severely deformed by Proteus syndrome. Merrick supported himself through young adulthood as a freak show exhibit but was later taken under the protection of the physician Dr. Treves and lived out the remainder of his life in London Hospital. In the play, Dr. Treves displays a voyeuristic obsession with Merrick, whom he sees as furthering his academic career. In support of this end, Treves facilitates a steady stream of upper-class visitors to Merrick's chambers. Their gaze, while ostensibly benevolent and charitable, in reality indulges both their and Dr. Treves' attraction to deformity and monstrosity.

Another illustration of voyeurism occurs in the short story "The Secret" by emergency room physician Frank Huyler (Huyler, 1999). This story recounts a situation in which the mouth of a severely injured man on a ventilator is overrun with maggots, which provokes a spree of fascinated ogling among the medical staff.

[1] Much of the professional analysis of the gaze is instead found in the nursing literature (Gastaldo & Holmes, 1999).

Since their stares occur while the patient is unconscious, there is no attempt to look beyond the medical curiosity to the person of the patient or even to obtain his permission for their gaping. When the patient awakes, he is surrounded by knowing smiles but never learns their cause. Both of these examples raise troubling questions about the presence of the voyeuristic gaze in the medical encounter.

The avoidant gaze. The avoidant gaze may characterize well-intentioned but insecure doctors who are fearful of becoming overwhelmed by their patients' suffering and do not want to engage interpersonally with patients. This gaze is rooted in the need to move away from the patient, thereby minimizing contact to escape intimate and feeling connection. The student-physician with few skills for emotionally addressing patients' distress and uncomfortable with intimacy may simply choose to avoid looking at his or her patient as much as possible. So may the cynical, burned-out physician who has no emotional resources left to expend through gazing.

Anatole Broyard, the former editor of the *New York Times Book Review* who died of prostate cancer in 1992, described this sort of gaze well (Broyard, 1992): "I think doctors have...a systematic avoidance of that click of contact...a generic unfocused gaze. They look at you panoramically. They don't see you in focus." In the short story "Outpatient" (Warren, 1990), Dr. Heller mostly looks at the chart or the wall, anywhere but at his patient, Luisa. "He looks into the distance, concentrating. He doesn't look at her." These writings remind us that we can pretend to look at someone without really seeing them.

The scientific gaze. The Foucauldian gaze of analysis and detachment implicitly solved the problems of both voyeurism and avoidance. This mode of looking eliminates exploitation *and* evasion because its aims are no longer personal or emotional but scientific and rational. In effect, it provides a weapon and a shield against the Scylla of submitting to one's own baser impulses and the Charybdis of being emotionally overpowered by the patient's suffering.

The Foucauldian gaze is perfectly captured in the poem "Technology and Medicine" (Campo, 1994). The author, an internist, Harvard professor, and respected poet, laments that his medical education transformed him into a kind of Frankensteinian man-machine – "My eyes/ Are microscopes and cathode X-ray tubes/ In one" – who sees only bacteria, bones, and blood chemistry. In the process of developing this newly trained vision, he fears he has lost his ability to understand that his patient is someone "just like me." This gaze is also well represented in the poem, "The Doctor Who Sits at the Bedside of a Rat." (Miles, 1967). In this poem, the physician approaches the patient as a lab animal, and observes only "...a paw twitch, an ear tremor, a gain or loss of weight." The author acquiesces (ironically) that these must be the only sources of data worthy of physician attention. Both poems disconcertingly portray the gaze of objective scientific curiosity that sees the patient as Other, a specimen for examination and treatment.

The patient gazes back. Unskillful forms of physician gazing, whether ordinary or scientific, are often met with equally questionable patient gazes. Rather than expose their vulnerability to the critical eye of the physician, patients may respond with despair, cynicism, rage, or withdrawal. *The Elephant Man* portrays John Merrick rebelling against the voyeuristic gaze aimed in his direction by becoming a voyeur himself. He stares at that most forbidden object in Victorian society, the exposed body of a respectable woman, using his anger to challenge conventions regarding who is empowered to stare at whom. In "Outpatient" we find what is likely a

widespread, but also cynical and aggressive, patient fantasy. The patient Luisa, who happens to be a skilled hypnotist, turns the tables on her competent but unfeeling physician by first putting him into a trance, then forcing him to undress and sit naked on the exam table. By contrast, the patients in the two poems cited above have lost their capacity to gaze at their doctors at all. In effect, their personhood has vanished from these poems. Finally, as a patient Anatole Broyard attempts to protect himself from the emotional vacancy he encounters in his physicians' eyes by adopting a consistently ironic, precious lens through which he then must perceive not only his doctors, but also his own dying.

GAZING BEYOND FOUCAULT TO POSSIBILITIES OF TRANSFORMATION

The above literary examples imply that it is difficult for both physicians and patients to shift the nature of the gaze in a more humanizing direction. Yet such transformation can occur. What kinds of gaze enable us to authentically acknowledge the subjective, particular experience of the suffering patient, or even to see the patient not as Other, but as Self? In literature, we find many instances of what might be termed witnessing or recognizing gazes. In these examples, we see the patient not as a passive, acted-upon object but rather as fully participatory in a relational process of mutuality and reciprocity.

The witnessing gaze. Witnessing is a term that grew out of the post World War II Holocaust literature and implies a willingness to be empathically present with, rather than turning away from, the suffering of others. Witnessing in medicine has been described as the ability to accept and honor, rather than diminish, patients' anguish (Frank, 1995). It incorporates an engagement between physician and patient that the Foucauldian gaze lacks (Davenport, 2000).

Fiction helps us recognize how the gaze can shift subtly but crucially from detachment to witnessing. Often it is the engagement of the patient in the encounter, something the patient does or reveals, that moves the physician's gaze to this new level. For example, in William Carlos Williams' classic story "A Face of Stone" (Williams, 1962), the doctor gazes coldly and reductively at the poor, uneducated, immigrant parents inexplicably worried about their normal healthy baby. The doctor literally sees them as stupid, ignorant animals. Later, however, he discovers that the infant's mother is a survivor of the pogroms. By being willing to understand the effects of this horrific experience on the woman's life and attitudes, the doctor begins to bear witness to the suffering she has endured. When next he looks at his patient, he sees her in a new, more compassionate way; the gaze she returns to him is similarly rehumanized.

In "Imelda," a short story by the Yale professor and surgeon Richard Selzer (Selzer, 1998), Dr. Franciscus, a renowned plastic surgeon, conducts a charity reconstructive surgery clinic in a remote Honduran village. In the title case, he examines a girl with a hideous cleft palate deformity. At first, his gaze sees only the anatomical error and the path to its correction, not the child's humiliation. Later, when his patient unexpectedly dies during the surgical procedure, Dr. Franciscus takes it upon himself to inform her mother. Yet he cannot find the words, and it is *she* who must tell *him* of her daughter's death. Confronted with this articulated reality, "He closed his eyes. Nor did he open them until he felt the touch of the woman's hand…Then he looked and saw the grief." At this moment, the physician is able to be fully present to the mother's suffering. As Selzer concludes, "There are events in a doctor's life that seem to mark the boundary between…seeing and perceiving."

The gaze of recognition. Another transformational way of looking is the gaze of recognition. Recognition represents an even deeper level of connection than witnessing in that it implies not only a respectful acceptance of the Other, but an understanding that, at some basic human level, the Self *is* the Other. Such a gaze apprehends the oneness and connection of all living things and thus reduces the distance between doctor and patient (Martin, 1976). Berger, in *A Fortunate Man: The Story of a Country Doctor* (Berger, 1967) discusses this phenomenon of "deep recognition." He implies that it is the patient's willingness to be vulnerable to the physician that allows the latter to accurately mirror the former, and in the process find him/herself reflected as well.

"The Appointment," by internist, professor, and ethicist Lawrence Schneiderman (Schneiderman, 1995), portrays a Mexican mother whose child has died seeking help at a community clinic. The usual gaze she encounters from the clinic physicians is a "cold" one. At the turning point of the story, a compassionate bilingual psychiatrist approaches the mother and speaks to her in her own language. "He does not look me over like the other doctors. Instead, he looks only into my eyes." Whereas the expression "looking over" conjures up images of inspection and evaluation, the psychiatrist's gaze acknowledges their shared humanity. This recognition of Self in Other facilitates the patient's struggle to confront her loss and begin the slow process of healing.

Doc in a Box (Burton, 1991) describes an encounter with a difficult patient complaining of a headache. When the protagonist Dr. Smith examines the man's eyes, he tries to remind himself that "he was looking at the man's retina, not his soul," but he cannot prevent himself from seeing "the red blur of sadness that covered all that the man saw." At this moment, patient and doctor exchange a gaze of recognition (both are suffering men, trapped in impossible circumstances), and a glimmer of understanding and human connection occurs.

In another Selzer story "Fetishes" (Selzer, 1998), a middle-aged woman, Audrey, facing surgery for a possibly malignant ovarian cyst, is terrified only that her husband will discover her secret–that she wears false teeth! Most of her doctors dismiss her concern as misplaced pride and remove their glance to that "vast, safe distance." But with one, a lowly, lame Indian intern, Audrey throws herself on his mercy and begs for help. Dr. Bhimjee understands Audrey's distress. "For a long moment they looked at each other, during which something, a covenant perhaps, Audrey did not know, was exchanged... deep called unto deep." Deep calls unto deep, soul touches soul, and doctor and patient recognize the suffering Self in the Other.

TRAINING THE CLINICAL GAZE: IMPLICATIONS FOR MEDICAL EDUCATION

The clinical gaze can be a valuable instrument of healing, an agent not simply of dividing, segmenting, and dehumanizing, but also of repairing and rehumanizing. It can be used either to emphasize the space that exists between patient and physician or to bridge that space. It would be naïve and misplaced to condemn the prevailing professional gaze out of hand, since its reductive, categorical, analytic approach is responsible for much of the successes of modern medicine. As Stoller (1996) points out, power has negative and positive aspects, energy as well as hostility, so it is both necessary and appropriate that the clinical gaze be informed by specialized expert knowledge. But it must also incorporate the human dimensions of relationship to function in a healing, as well as a diagnostic, manner.

For this reason, as Hick suggests, we

need to cultivate an art and science of perception, to help students recognize multiple gazes in both themselves and in their patients, learn when various types of gaze are appropriate, and know how to move comfortably among them in tandem with their patients' gazes (Hick, 1999; Davenport, 2000). Precisely because the gaze Foucault describes has become so widely disseminated, medical education must take special care to retain and refine other more humane forms of gazing in its learners. Physicians of necessity peer into vulnerability, hurt, and suffering, so they must have the ability to convey concerned, as well as analytic, observation (Norvedt, 1998), especially when the gaze of the patient is seeking such a response. As the French philosopher Levinas expressed the problem, to achieve a moral stance in medicine, it is important to regain access to "the primary, ethical vision of the patient's face," which is often lost under the scrutinizing scientific gaze (Levinas, 1982). To rehumanize and transform our clinical gaze, we first must be willing to look into our patients' eyes.

As clinicians and teachers, we must think seriously about how we want to exercise our gaze and how we want to train–or untrain–the gaze of others. Practically speaking, we know very little about how to do this, and systematic pedagogical suggestions must await further empirical and qualitative research into this important but neglected area. An important first step is making our gaze self-reflexive (Manias & Street, 2000), turning the gaze inward on ourselves as well as outward toward the patient. Indeed, several authors have pointed out that the controlling power of the gaze depends in part on its being a one-way phenomenon (Szykiersky & Rivas, 1995; Parker, 1995), so that while the patient must reveal all, the physician may remain hidden. Reflecting on and questioning the nature of our gaze will help us challenge its unconscious application and allow for the reintroduction of forms of looking that promote patient (and physician) well-being.

A second approach involves a willingness to pay close attention to the gaze of the patient. What is this gaze revealing? What does it hide? What is it asking of us? What does it want to share? The clinical gaze of the physician cannot be trained in a vacuum. Acknowledging the gaze of the patient as an equally influential element in the interaction is a crucial way of empowering patients. By developing sensitivity to the desires and fears conveyed in the patient's gaze (Campo, 1997), we will begin to learn what is required from our own reciprocating gaze.

Reclaiming a more humanizing gaze will probably be a futile task if approached on a purely scientific or procedural level (Toombs, 1992). But complementary approaches that combine emotional and intellectual engagement are available to us. As suggested by the above discussion, one way to accomplish physician simultaneous self-reflexivity and awareness of patients is to expose physicians-in-training to imaginative literature and first-person narratives by patients and physicians that examine the gaze. The reflective process can also be encouraged through journaling and other forms of reflective writing. A further way to stimulate reflection on and generate ideas about working with the clinical gaze is to examine it through Balint groups, which provide an ideal forum for examining the interpersonal and intrapersonal qualities that either push physicians away or move them toward their patients (Balint, 1957). Finally, to explore the myriad potentialities of the clinical gaze, we can turn to the role-modeling of wise and compassionate clinical teachers. These individuals, by highlighting and explicating their own shifts among various types of gaze, can help students recognize the importance of how to look as well as help them discriminate proper and respectful uses of the gaze.

Perhaps as clinicians we can never completely eliminate elements of the voyeuristic gaze. At times, it may be that we must confess our emotional inadequacies and seek refuge in an avoidant gaze. Sometimes the detached clinical gaze is both necessary and appropriate. Of greatest importance is that we learn to pay attention to and cultivate the ability to "shift" our gaze in dynamic interaction with our patients to other, more humane dimensions. When we are successful in this task, our routine looking at patients becomes a reciprocal gaze of connection, witnessing, recognition, and therefore transformation.

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International Exchange of Experienced Family Therapists between North America and New Zealand

The Hutt Valley District Health Board's Child, Adolescent & Family Service, located at Lower Hutt Hospital, Wellington, New Zealand, seeks expressions of interest from a similar service within the United States or Canada interested in exploring the mutual exchange of experienced family therapists for a period of 12 months.

We are a multi-disciplinary out-patient mental health service with a staff of 30 - 35 practitioners. The prominent modality of our work is Family Therapy.

The purpose of the exchange would be for the visiting clinicians to gain experience of other clinical practice within the field of Family Therapy, personal professional development including unique training opportunities, information and cultural exchange, and international networking.

The concurrent exchange of a family therapist from each service means a temporary staff position, and possibly accommodation, could be available for each visitor.

If your clinic or service is interested in pursuing this idea further please email us at either *child.and.family@hvh.co.nz* or *avoca@ihug.co.nz* to further develop the concept.