CHAPTER 18

Crossing the Chiasm: Sutured Care in Medical Education

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Medicine, "the science and art of diagnosing and treating disease or injury and maintaining health," (Merriam-Webster, n.d.) is a contested field. In the Western world, science is dominant. While its contribution to patient care is indisputable, its dominance too easily excludes artful ways of knowing. This piece highlights an alternative way in which a doctor's and a patient's co-participation in an act of healing led them to appreciate and understand each other. My narrative focuses on the body, not as a scientific object but as a sensate perceptual tool, which mediates human connection. I describe how suturing, in the technical medical sense of the word, sutured together, metaphorically, two embodied individuals. In doing so, it bridged the privileged sociocultural world of medicine and the fragile world of a person who frequently harms herself. This narrative illustrates how teaching and learning about our bodies—so-called body pedagogics—allows embodied experience to bridge distance and inequality between physician and patient.

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We have seen each other almost every month for over 10 years. In 15 minute aliquots, we discuss day-to-day events and family life. Occasionally I carry out a physical examination. Routine doctor-patient visits. Time is planned and documented, and care is managed. A professional relationship. Over the years, Mary and I exchanged many birthdays, Christmases, and family events; significant relationships have come and gone in our lives, but our time together is constant. Life has not been kind to her; she struggles with mental and physical health issues. Diagnostic codes, prognostic indicators, and management steps. In more recent times, Mary's grapples have turned inwards and she cuts her body. Her white soft skin is traced with a lattice of fine scars from razor blades and knives.

Mary sits in her chair beside my desk and I settle back in my chair. My eye is drawn to a dark stain on her jeans. The slices on her thigh are deep and need closure. What has Mary done? How can she inflict such pain on herself? We do not talk. I set about my job. Gently I peel the soaked denim from her skin, the blood has clotted and my actions cause fresh blood to ooze forth. I clean the wound, it stings. Mary sits stoically, unflinching. Then I inject local anesthetic by aligning the needle parallel with her lacerations and watch it flood the gouges. I hold the exposed edge of flesh and insert the curved suture to draw the thread through her skin and tie the knot tightly with precision. It is I who feels the pain; my powerlessness to change her situation. It is almost unbearable. My vision blurs and a salty tear drips, fills the gash, and runs uncontrolled down the curve of her thigh. I gulp and struggle for breath. My strangled sound breaks the silence. I feel a gentle hand on the back of my neck, through my hair. 'It's OK' she says. In that slow motion moment, proprieties dissolve and our relationship is transfixed; who is healer and who is the wounded? Our eyes meet.

Why has this experience niggled? What was it about my stifled breath, and Mary's touch that made me feel so vulnerable? That split second has challenged me, stimulated me to question my practice and led me to explore the idea of *body pedagogics* (Shilling & Mellor, 2007) in medicine—how we transmit corporeal techniques, and the embodied experiences associated with learning. My initial reaction to my tears and Mary's comfort was distress—"How could I be so unprofessional?" I ask myself. I broke a cardinal rule, displayed emotion and, even worse, infected a sterile field. It felt very strange to be touched with such care by a patient. Again, I worried. Had I transgressed another rule, gotten too close, crossed a boundary? The professional voice of my training challenged my *humanitas*. My sense of belonging to something bigger than myself knew that something amazing had occurred; our

sociocultural worlds had collided. There was no power differential, no pseudo language of 'gnosis;' we were sutured together. In that instant, Mary and Martina experienced each other in a deeply humane way. It was a healing moment. And that moment was embodied.

Merleau-Ponty wrote about the body as the constant means by which we experience the world. It is impossible to separate our bodies from who we are and what we do; the body opens up new points of view. To experience a structure is "not to receive it into oneself passively: it is to live it, to take it up, assume it and discover its immanent significance" (Merleau-Ponty, 1945/1962, p. 258). Using the metaphor of chiasm, Merleau-Ponty (1964/1968) described a process of intertwining, where the porous boundaries of two people crisscross and merge to "function as one unique body" (p. 215). Mind and body become an indivisible, therapeutic whole. These ideas are reminiscent of a more descriptively embodied version of Buber's (1970) I-Thou relationship, where the uniqueness of the Other is fully appreciated. For both philosophers, things happen in the 'inter;' a space in between two beings that is, of itself, creative.

As a physician, these ideas are extremely challenging. Formal learning espouses scientific principles of empiricism and objectivity. Medicine could be considered a practice of distance—rather than a chiasma, there is a chasm. Some of this is historical—physicians were typically male, often from a higher social class. Scientific thinking required learners to dissociate themselves from the physical and emotional turmoil of practice and develop an 'objective gaze.' Distance is also physical—perhaps initially practical, to guard against the hazards of infection, but it remains. Physicians do their rounds protected by white coats. Patients' vulnerability is made apparent as they lie in bed, in night attire. Taken together, these factors reenforce a power differential between doctor and patient. Recent attempts to suture this gap have resulted in a reconsideration of professionalism in medicine, but boundaries remain.

Yet medicine is also a practice of contiguity. As I examine patients, I probe and access parts of their bodies rarely revealed to other human beings. I share deeply emotional journeys of sickness and health; there is a sanctity to the doctor-patient relationship that can only be disclosed by law. Such closeness tends to be cloaked by a language of competence and professionalism. A discourse of care is less vocal. Ironically, a call to care, an idea of *connecting* with others, is what motivates many of us to become physicians. Caring is a physical process—think, for example, of nurturing a child.

There is a pedagogical paradox. Central to the study and practice of medicine is the body. Students learn the what, where, and how of bodily (dys)function. They also learn *with* their bodies. Physical examination techniques and procedural skills rely on detection of physical sensations, reactions, sights, and sounds. Over time, these skills become almost automatic and tacit. Proficiency requires familiarity with normality and abnormality—and the subtle differentiation between both is recognized and rewarded as the skill of an expert. The body as competent. What about the body as care? Poirier (2006) suggested that medicine is a pedagogy of disembodiment. Long hours, sleep deprivation, and physical hunger become embodied as part of a learning process, which facilitates the practice of distance. Learners are trained to ignore their physical needs and responses. In learning to become 'objective,' students suppress, become more guarded to express, and pay less attention to 'gut instinct' or the physical sensations induced by the emotional reaction of a distressed person in pain; they learn how to embody the chasm. Yet, is it possible that alternatives exist?

*The term *empathy* originates from the German term *Einfühlung*, which means 'feeling into'

Questions

1. In a well-meaning pursuit of professionalism in medicine, to what extent have we relegated the importance of 'feeling into'* the other, using an embodied form of empathy?
2. What alternative methods of teaching could enable medical students to become more physically self-aware, to attune, respond to, emotions and bodily reactions?
3. How might touch, explored through the metaphor of the chiasma, suture sociocultural differences in health care?

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Related Further Reading

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