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# Doctored Images: Enacting "Pain-Work" in John Berger and Jean Mohr's *A Fortunate Man* (1967)

Bassam Sidiki[1]

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**Abstract**
This essay argues that Berger and Mohr's *A Fortunate Man* (1967) – comprising social observation and photographs of the rural practitioner, Dr. Sassall and his patients – enacts an embodied, intersubjective empathy called "pain-work." The book enacts "pain-work" through two strategies. Firstly, by conflating three ways of seeing – Berger's observation, Mohr's photography, and Sassall's medical gaze – it shows that the clinical encounter embodies objective vision through intersubjective pain. Secondly, it employs the concepts of recognition and witnessing to show how the subjectivity of the physician is distributed in his community. Thus, Berger and Mohr witness Sassall's witnessing of his patients; even as Sassall and his patients are constituted intersubjectively, so too are Berger, Mohr, and Sassall.

**Keywords** Pain · Recognition · Witnessing · Enactment · Intersubjectivity

## Introduction

The opening pages of John Berger and Jean Mohr's *A Fortunate Man* feature two landscape photographs of the Forest of Dean in Gloucestershire, England, with each photograph spread over two pages. The pictures are in grayscale; the first (Figs. 1 and 2) depicts a luscious rural landscape with a body of water in the foreground – a little raft holding two fishermen can be seen in the bottom left corner of the spread – while farmlands and forested hills recede in the background. In the top right corner of the spread, in the white patch of sky, there is a bit of text that reads: "Landscapes can be deceptive. Sometimes a landscape seems to be less a setting for the life of its inhabitants than a curtain behind which their struggles, achievements and accidents take place" (Berger and Mohr 1967, 13). The next photograph (Figs. 3 and 4) portrays a dark forest that takes up a third of the spread, perhaps snapped at dusk, and a few brightly lit houses appear as little white interruptions in a sea of black. Like these white houses,

✉ Bassam Sidiki
basidiki@umich.edu

[1] The University of Michigan (Department of English), Ann Arbor, MI, USA

**Fig. 1.** A black-and-white photo of a rural landscape, with wooded hills receding in the background, a field with fences in the center, and a body of water in the foreground. There is a boat in the left corner of the photograph, with two men fishing. (Berger and Mohr 12)

the following white sentence graces the bottom right corner of the black landscape: "For those who, with the inhabitants, are behind the curtain, landmarks are no longer only geographic but also biographical and personal" (15).

*A Fortunate Man*, characterized by its blurb as a "quietly revolutionary work of social observation and medical philosophy," thus begins as an invitation to the readers to first behold the darkness and mystery of the landscape where, as they will soon find out, the titular fortunate man lives and works. A text following the daily life of a rural general practitioner, the pseudonymous Dr. John Sassall, opens not with the "fortunate man" that is its subject but with the landscape amidst which and the people among whom he practices. This insight anticipates the general two-pronged argument of this essay: that the doctor, his patients, and the countryside are mutually constitutive and that their identities are produced through intersubjective experiences of embodied pain. In a similar vein, Berger's text and Mohr's accompanying photographs – depicting Sassall's "pain-work" which allows the mutual constitution of doctor, patient, and landscape – are themselves inextricably intertwined with Sassall and his "doctoring." The sociological, photographic, and clinical gazes that compose the text are therefore *enacted* in a way that it becomes difficult to separate them. As Berger once said about his book in an interview many years later: "as a book, it mixes a whole series of approaches: in places storytelling, in others analytic, sociological, pictorial—and in this respect is resembles Sassall, who was incredibly versatile" (Huntley 2001, 546). Indeed, as will become clear in this essay, it is often difficult for the reader to decide where the subject of the book, Dr. Sassall, ends and where Mohr and Berger begin. Thus, different "ways of

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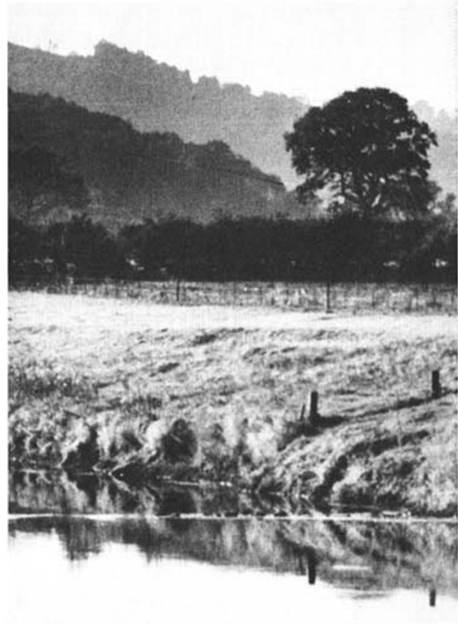

**Fig. 2.** A black-and-white photo of a rural landscape, with wooded hills receding in the background, a field with fences in the center, and a body of water in the foreground. A large tree appears on the right edge. The sky beyond the hills is white and serves as background for following prose, printed in black: "Landscapes can be deceptive. Sometimes a landscape seems to be less a setting for the life of its inhabitants than a curtain behind which their struggles, achievements and accidents take place." (Berger and Mohr 13)

seeing" – the clinical gaze, social observation, and photography – work together to enact "pain-work."

By "clinical gaze" I refer to the theorization of medical perception by Michel Foucault in *The Birth of the Clinic* (1994). In that seminal text, Foucault traced the conditions of possibility for the emergence of a positivist gaze in the medical sciences at the beginning of the nineteenth century. At the time, physicians and anatomists began to move away from the theories of Galen and Hippocrates, electing to dissect bodies and get at the *observable* etiologies of disease. "[D]octors described what for centuries had remained below the threshold of the visible and the expressible," Foucault writes. "The relation between the visible and the invisible…changed its structure, revealing through gaze and language what had previously been below and beyond their domain" (xii). For Foucault, "the eye becomes the depositary and source of clarity; it has the power to bring a truth to light," and "the residence of truth in the dark center of things is linked, paradoxically, to this sovereign power of the empirical gaze that turns their darkness into light" (xiii-xiv).[i] While the clinical gaze is still very much in operation in Sassall's pain-work – as indeed it must be for all kinds of doctoring – this essay supplements his clinical gaze with new models of clinical empathy and intersubjectivity which allow us to look more fully inside conventional relationships.

One of these models is what medical anthropologist Annemarie Mol calls "enactment." The implications of the clinical gaze were not just epistemological but ontological. As Foucault argued, the very structure of relations between the visible and the invisible underwent a mutation. There emerged "a new distribution of the discrete elements of corporal space" and "a reorganization of the elements that make up the pathological phenomenon" (xviii). In a

**Fig. 3.** A black-and-white photo of a rural landscape snapped at dusk. The wooded hills appear as black and the sky as white. Some lit houses appear as white blotches in the blackness. (Berger and Mohr 14)

section titled "The Clinical Gaze Effects a Nominalist Reduction on the Essence of the Disease," he considers the question

> But what, then, is pleurisy?... It is the concourse of the accidents that constitute it. The word pleurisy merely retraces them in a more abbreviated manner. 'Pleurisy' has no more being than the word itself: it 'expresses an abstraction of the mind'; but, like the word, it is a well-defined structure, a multiple figure in which all or almost all the accidents are combined. (119).

Foucault's observations about pleurisy being a "multiple figure" anticipate Annemarie Mol's groundbreaking *The Body Multiple* (2002), in which she goes further than Foucault to interrogate the ontologies of a disease – in her case, atherosclerosis. While she follows Foucault's idea about the "nominalist reduction" of different atheroscleroses into a single entity with a single etiology, she takes the clinical gaze further: it doesn't just *name* different phenomena as one, like in Foucault's argument, but it can also obscure the practices that constitute a disease differently in diverse contexts. Mol calls these practices of making a disease *enactment*: atherosclerosis is different under the microscope than it is in the consulting room, which means that a disease is never just one "thing" – its ontology is necessarily context-dependent. It is a *multiple* figure. In fact, as opposed to Foucault for whom pathological anatomy came first in the making of the clinical gaze, for Mol the pathological ontology of atherosclerosis is secondary; the disease first appears in the consulting room and then in the autopsy room. Thus, paying attention to enactment as a method lays bare the varied practices

**Fig. 4.** A black-and-white photo of a rural landscape snapped at dusk. The wooded hills appear as black and the sky as white. The following prose in white lettering appears at the bottom of the image: "For those who, with the inhabitants, are behind the curtain, landmarks are no longer only geographic but also biographical and personal." (Berger and Mohr 15)

that the clinical gaze obscures. Ironically, the clinical gaze – which has long prided itself on unveiling and bringing things to light – engenders its own obfuscation.

This detour into enactment and ontology has implications for my reading of Berger and Mohr, and their reading of the titular "fortunate man." Just like Mol's atherosclerosis, Sassall is a multiple figure: he is the countryside and his patients. Likewise, the book *A Fortunate Man*, a metonym of Sassall, is also many things at once: social observation, photography, biography, philosophy. Mohr's photographs and Berger's text lay bare the numerous enactments through which Sassall becomes himself. While through the clinical gaze a "new alliance was forged between words and things, enabling one *to see and to say*" (Foucault 1994, xii), Berger's observations and Mohr's photographs are shot through with doubts about what they see and what they say. As Berger writes toward the end of the book, his assessment of Sassall remains inconclusive because the latter is "a work in progress" (159). He differentiates his account of Sassall from fiction or autobiography. In those genres, a character or a life is decided beforehand, whereas in the case of Sassall, a living being, Berger "can decide nothing… I am entirely at the mercy of realities I cannot encompass" (158-59). In Berger's writing Sassall is a figure, like in a lot of his photographs by Mohr, whose boundaries are rendered more and more blurry, complex, and indeterminate, a quality that is the product of multiple enactments.

Thus, we find Mol's concept of enactment illuminating a literary or photographic method of representation. Notably, the literary critic F. R. Leavis has already theorized for us how literature, through embeddedness in language, *enacts* its meanings and ethical commitments instead of simply stating them (Moyal-Sharrock 2016, 249-50). In her discussion of Leavis and

Wittgenstein, Moyal-Sharrock writes that "the important things don't get expressed by our saying them; it is when language is used to tell stories that the important things get expressed" (253). Drawing on D. D. Hutto's work on "enactivism" – the theory that cognition emerges through a dynamic interaction between an organism and its environment – she argues that meaning enacted in literature is grasped through a "nondiscursive form of embodied cognition" (quoted in Moyal-Sharrock 2016, 251). This embodied cognition, in addition to the somewhat necessarily detached clinical gaze, permeates the works of Berger and Mohr. But it is also enacted in their representation of Sassall's own practices through what I call "pain-work."

## Pain-work: punctuating the text, puncturing the body

In *The Body in Pain*, Elaine Scarry notes how "vision and hearing are, under ordinary conditions, so exclusively bound up with their object rather than their bodily location that they are the senses most frequently invoked by poets as the sensory analogues for the imagination. Through them, one seems to be disembodied" (1985, 165). It is only through pain that vision or hearing can be embodied. She continues: "Although vision and hearing ordinarily reside close to objectification, if one experiences one's eyes or ears themselves – if the woman working looks up at the sun too suddenly and her eyes fill with blinding light – then vision falls back into the neighborhood of pain" (ibid.). John Sassall himself attests to this slippage between vision and pain. Berger relates an episode where the doctor is injecting a syringe deep into a man's chest, and the latter explains his "revulsion" by saying: "That's where I live, where you're putting the needle in." Sassall responds, "I know… I know what it feels like. I can't bear anything done near my eyes. I can't bear to be touched there. I think that's where I live, just under and behind my eyes" (50). Interestingly, right across from the page with the above text is an oversize, close-up profile of Sassall examining something closely using a loupe in one eye and with the other eye straining in concentration and a scalpel in his hand (Fig. 5). The image and text demonstrate that Sassall's vision is always, in Scarry's terms, somewhere in the "neighborhood of pain," such that it allows him to empathize with his patients through an embodied cognition, a re-cognition.

But apart from Sassall's own comments, Mohr's accompanying images, especially Fig. 5, allow us to see how photography introduces embodied pain into the otherwise disembodied vision of the clinical encounter and also, of the reader's encounter with *A Fortunate Man*. One would expect that photography, the visual medium par excellence, merely reproduces the disembodied ocular regimes of medical practice, but Roland Barthes would argue that embodied pain is a major component of how we behold photographs. In *Camera Lucida* (1981), Barthes writes that there are two kinds of emotional attitude which one can adopt toward photographs. The first he calls *studium*, an emotional reaction to a photograph by virtue of one's being in a particular "ethical and political culture"; it is "a kind of general, enthusiastic commitment, of course, but without special acuity" (26). The second emotional reaction he terms *punctum*, an element of a photograph which the viewer himself does not "seek out (as I invest the field of the stadium with my sovereign consciousness)" but which "rises from the scene, shoots out of it like an arrow, and pierces me." *Punctum* has the same root as "punctuate," and for Barthes, photographs can be punctuated or speckled with these tiny, at first inconspicuous, points which "prick" him and leave him wounded. Pages fifty through fifty-one of *A Fortunate Man*, with Figs. 5 and 6 across from each other, the former

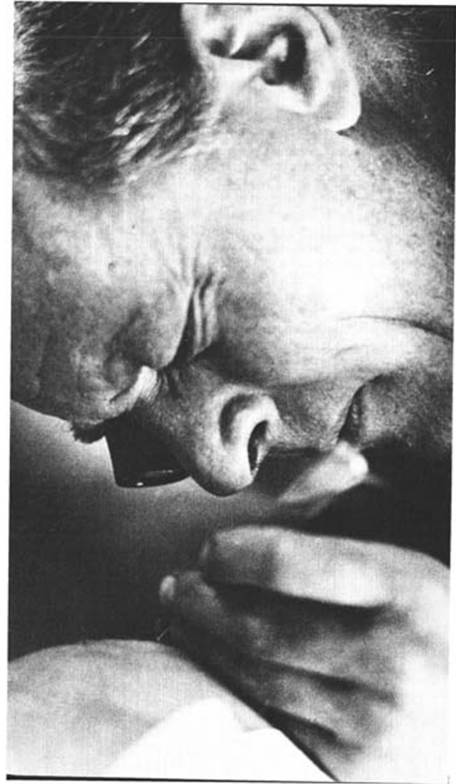

**Fig. 5.** Grayscale, closeup photograph of Dr. John Sassall examining something with a loupe in one eye, with the other eye straining in concentration, and his hand holding a scalpel. (Berger and Mohr 51)

showing Sassall's profile and the latter depicting him at work on a man's bandaged wrist, illustrate the many levels of literal *punctum*: even as Sassall pierces a man's wrist, he himself is pierced.

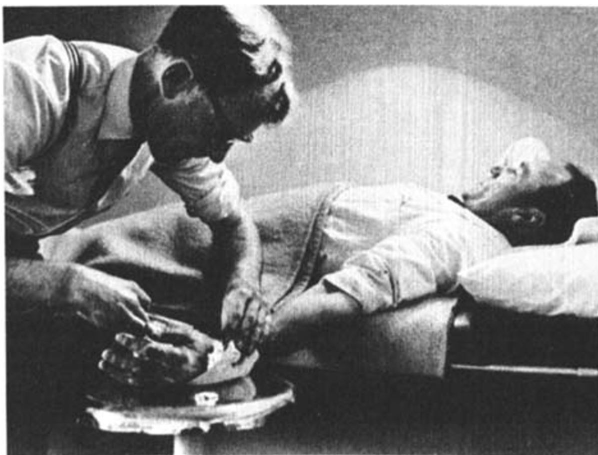

**Fig. 6.** Black-and-white photograph of Dr. John Sassall working on a man's bandaged wrist. Sassall appears in the upper left corner of the image. The patient, a man, is lying down on a bed, his eyes closed. (Berger and Mohr 50)

The viewer of Mohr's photographs is pierced, too. According to Barthes, "The photograph is literally an emanation of the referent. From a real body, which was there, proceed radiations which ultimately touch me, who am here…A sort of umbilical cord links the body of the photographed thing to my gaze: light, though impalpable, is here a carnal medium, a skin I share with anyone who has been photographed" (80-1). On Barthes's account, the photographs of Sassall and his patients in *A Fortunate Man* would also puncture and pierce the reader, not least because they are a historic record of the very light which produced them on the day they were taken; we do not just look at the photographed bodies, but they in fact "touch" us, rendering the visual encounter as embodied and tactile as skin. It is also significant that the photographs in *A Fortunate Man* are all black-and-white. For Barthes, these kinds of images are preferable to the technicolor ones because

> I always feel (unimportant what actually occurs) that in the same way, color is a coating applied later on to the original truth of the black-and-white photograph. For me, color is an artifice, a cosmetic (like the kind used to paint corpses). What matters to me is not the photograph's "life" (a purely ideological notion) but the certainty that the photographed body touches me with its own rays and not with a superadded light. (81)

Mohr's black-and white images further accentuate the puncturing of the reader, the rays reflected by the photographed bodies unadulterated by color. But even if the images were technicolor, the point remains that a photograph is a "certificate of presence" (87), a trace which ratifies the bodily presence of the photographer and not just that of his camera. This presence of the body in addition to the visual modalities of the eye is also an important component of the practice of witnessing, on which I will elaborate in the next section.

Mohr's photographs therefore do not so much accompany as *punctuate* Berger's text, even as the text itself gives the images their necessary context. As Susan Sontag argues in *On Photography* (1977), photographs almost always outlive the immediate sociopolitical context in which they were produced, which is why "socially concerned writers" like Berger are "often enlisted, or volunteer, to spell out the truth to which they testify" (83). This combination of image and text isn't dissimilar from how clinical practice must make use of both vision and narrative – the diagnosis is made by using visual technologies and by taking a history of the patient. Barthes's *studium* and *punctum*, moreover, provide a photographic metaphor for empathetic medicine: physicians like Sassall look at their patients how Barthes looks at photographs, receptive to the *punctum*s which speak to each patient's individuality rather than the *studium* of general interest. It is this *punctum* which embodies the otherwise disembodied vision of the physician, constituting an important feature of his (and Berger and Mohr's) pain-work.

In my coining of "pain-work," I return to Scarry, who argued in her major text that pain and work exist in a dialectic. "It hurts to work," she writes. "Thus, the wholly passive and acute suffering of physical pain becomes the self-regulated and modest suffering of work. Work is, then, a diminution of pain: the *aversive intensity* of pain becomes in work *controlled discomfort*" (1985, 171, her emphasis). On Scarry's account then, vision and pain and work are triangulated: pain embodies vision, while work mitigates pain. All three are operating in Berger and Mohr's enactment of Sassall and in Sassall's own medical practice. As Berger writes: "Guilty, [Sassall] becomes increasingly susceptible to the suffering of others… To deny this, he tries, as we have seen, to compete with the intensity of suffering. He will work as hard as they suffer. His attitude to his work becomes obsessional" (146). Toward the end of the text, Berger quotes Sassall himself: "'Whenever I am reminded of death – and it happens every day – I think of my own, and this makes me try to work harder'" (168). Sassall works hard to ease both his pain and that of his

patients but, paradoxically, his work engenders even more pain for him, trapping him in a vicious cycle.

In Berger's descriptions of Sassall and his quotations of the latter, it might as well be Berger himself who is speaking, projecting his own fears of death and his tireless work ethic onto the similarly workaholic Sassall. After all, Berger and Mohr's work documenting the painful stories of the dispossessed and marginalized the world over, using words and images respectively, is nothing short of revolutionary. The entire text is focalized, to use another visual metaphor, through Sassall, even though it is Berger who is speaking. Moreover, the text often switches between descriptions of Sassall and his patients, Sassall's own words, and Berger's philosophizing, enacting a kaleidoscopic narrative where individual identities are rendered indeterminate. Even as Berger writes twice in the text, when describing the rural scenery, that "every leaf of each tree seemed separate," Berger's, Mohr's and Sassall's individual works become enmeshed to form an arbor in which it's not clear where one leaf ends and another begins, their subjectivities bleeding into each other.

Perhaps *A Fortunate Man* also testifies to the often-debated notion that "all biography is a form of autobiography" (Lee 2009, 12), and that complete objectivity is impossible because the biography is a record of the intermingling subjectivities of author and subject. It is important that Berger was once Sassall's patient; he was living in a neighboring village and sought the latter's services when he had severe abdominal pain and thought it might be an ulcer (Huntley 2001). The two became friends thereafter, and it is inevitable that Berger's writing about Sassall was influenced by the memory of pain and its amelioration. Significantly, it is pain that inaugurates Berger's project about Sassall, and the objectivity of his narrative is laced with it – it is another kind of pain-work.

While Mohr himself was not Berger's patient, the "I" of the photographer can also be said to permeate Sassall, his patients, and the landscapes of the Forest of Dean. As Sontag writes, quoting a couple of photographers, "For Lange every portrait of another person is a 'self-portrait' of the photographer, as for Minor White—promoting 'self-discovery through a camera'—landscape photographs are really 'inner landscapes'" (2005, 95). The landscapes that grace the beginning of the book and which invite the reader to unveil what lies behind them, therefore, might as well be invitations into Mohr's own "struggles, achievements, and accidents." Moreover, the many frontal portraits in the book, especially those of Sassall's patients', suggest a kind of vulnerability and trust in the photographer which they usually reserve just for the doctor. As Sontag writes about Diane Arbus's portraits: "frontality also implies in the most vivid way the subject's cooperation. To get these people to pose, the photographer has had to gain their confidence, has had to become 'friends' with them" (30). Like a photographer, Sassall must also gain his patients' confidence and trust in order to treat them. Conversely, as the photographer Richard Avedon once said, "I often feel that people come to me to be photographed as they would go to a doctor or a fortune teller—to find out how they are" (quoted in Sontag 2005, 146). In these ways, Mohr becomes intimately part of Sassall's pain-work, while also translating through the *punctum* of his photographs the experiences of pain which Sassall witnesses daily.

## Pain-work: recognition and witnessing

> … the suffering which certain doctors *witness* may be more of a strain than is generally admitted. This is so with Sassall… I saw him weep, walking across a field away from a

> house where a young patient was dying… He would transform his pain into a sense of *painful responsibility*, for that is his character.
> But this sensibility is not just the consequence of his character: it is equally the consequence of his position and the way he practices… He does not believe in maintaining his imaginative distance: he must come close enough to *recognize* the patient fully. (112-113, my emphases)

In this passage we find two ideas central to Sassall's pain-work and its representation by Berger and Mohr: recognition and witnessing. Particularly with respect to Sassall's weeping, I find useful Kelly Oliver's invocation of Derrida's argument from *Memoirs of the Blind* that "the eye would be destined not to see but to weep… the blindness that opens the eye is not the one that darkens vision. The revelatory or apocalyptic blindness, the blindness that reveals the very truth of the eyes, would be the gaze veiled by tears" (quoted in Oliver 2015, 482). Thus, rather than practicing solely through a disembodied vision, we find Sassall engaged in a practice that recruits other, non-visual modalities of the eye.[ii]

Berger often belabors the point that Sassall must recognize his patients in their entirety. As he writes:

> The whole process, as it includes doctor and patient, is a dialectical one. The doctor in order to recognize the illness fully – I say fully because the recognition must be such as to indicate the specific treatment – must first recognize the patient as a person: but for the patient – provided that he trusts the doctor and that trust finally depends upon the efficacy of his treatment – the doctor's recognition of his illness is a help because it separates and depersonalizes the illness. (74)

This no doubt evokes Hegel's master-slave dialectic (*Phenomenology of Spirit,* 1807), a relation of mutual recognition between one person and another but which also always involves the possibility of one killing the other. As Charles Taylor notes in his essay "The Politics of Recognition," Hegel was one of the first to move away from the ethics of honor and pride so prevalent in earlier societies toward an ethics of dignity based on mutual recognition (1992, 50). In invoking Hegel's dialectic, Berger troubles the disembodied ocularcentrism of medical practice and makes it subject to the patient's recognition of the physician; after all, the patient must "trust" the physician and his capabilities in order for the clinical encounter to proceed (just as he must trust the photographer, as we saw above).

Perhaps we can again engage Annemarie Mol for our purposes here. Janelle Taylor (2008), in her autoethnographic account of caring for her mother with dementia, finds it useful to fuse the "politics of recognition" with Mol's "politics of what." For Taylor, the medical anthropologist, the account of recognition politics theorized by Taylor the philosopher is too limiting and must look beyond "individuals as the bearers of 'selfhood,' and start looking more at how 'selfhood' is distributed among networks, sustained by supportive environments, and emergent within practices of care" (2008, 326). On Janelle Taylor's account, then, Berger represents Sassall's medical practice as productive or enactive of his own and his patients' identities, such that their respective selves are rendered distributed and indeterminate:

> [Sassall] tries to recognize each patient and, having recognized him, he tries to set an example for him – not a morally improving example, but an example wherein the patient can recognize himself. One could simplify this… by saying that he 'becomes' each

> patient in order to 'improve' that patient. He 'becomes' the patient by offering him his own example back. He 'improves' him by curing or at least alleviating his suffering. (77)

Just as Richard Avedon's subjects recognize themselves in his photographs of them – they find out "how they are" – Sassall too works to assist his patients in recognizing themselves. We can now see how recognition contributes to pain-work: the reason that the suffering of his patients affects Sassall to such an extent is because selves in this rural community are produced – or enacted – through the recognition embedded in care practices. It is then no wonder that in a book titled *A Fortunate Man*, we find as many photographs of Sassall's patients as of himself; his selfhood is distributed among his patients, and the photographs further enact this "becoming patient." Consider the five images (Figs. 7a – 7e) that follow the paragraph ending with "the function of fraternity is recognition" (69). They are a series depicting one scene: Sassall speaking to an old woman, presumably one of his patients. In the first image, we see Sassall standing in profile at the left edge of the photograph, his eyeglasses directed down to where the lady is sitting. The former's boundaries are well-defined in this photograph but start to become blurry in the next four where we only see the back of his head. In these subsequent images, it is the patient who is the focus of the photographs, and by having us look at her face over Sassall's fuzzy head and shoulders, Mohr enacts the very dissolution and distribution of the physician's self about which Berger writes so eloquently.

Sassall's recognition of his patients chimes well with Janelle Taylor's meditations in another significant aspect. Taylor expresses in her article the extent to which her mother's dementia led to her being abandoned by her close friends and much of her extended family, resulting in a kind of "social death." For Taylor, the question "does she recognize you" is irrelevant. What matters is whether we recognize the patient with dementia as a person. Berger shows that such social abandonment is a key space where the doctor's recognition of the patient as a person can make a difference: "In illness many connexions [sic] are severed…The doctor, through his relationship with the invalid and by means of the special intimacy he is allowed, has to compensate for these broken connections and reaffirm the social content of the invalid's aggravated self-consciousness" (69). Because the physician's self is enacted and distributed among the community, his or her recognition of the patient has higher stakes: it stands in for the community's and thereby repairs the links that have been severed. Especially through a medical anthropological lens, this analysis is not controversial. After all, as theorized in so much of the literature, illness is not just a biological or personal but a social crisis. This is evident in another place in the text where Sassall considers it "his duty to try to treat at least some forms of unhappiness. He very seldom sends a patient to mental hospital for he considers it a kind of abandonment" (113). This latter quote evinces another aspect of Sassall's pain-work: the mitigation of mental or psychological anguish through practices of recognition that reinforce social ties.

As important as recognition seems to be for the project of pain-work, Berger and Mohr express some reservations about its efficacy, not least because of Sassall's privilege relative to his patients. On numerous occasions, Berger comments on the difference in capital – social or otherwise – between the physician and the people he sees. And this "recognition" of his own privilege contributes to the "guilt" or "painful responsibility" that Sassall feels about his position. Berger describes the region in which Sassall works as one of "extreme cultural deprivation" (100), so that he has to spend enough time with them in order to "qualify for their conversation." Though Sassall believes that this shared language reflects the rest of their

**Fig. 7.** **a** Black-and-white photograph of Dr. John Sassall speaking to an elderly lady. Sassall stands at the left edge of the photo while the lady is sitting on the right, looking up at the doctor. One can see between the two a lighted lamp, a small painting in a square frame, and above it a larger painting in a circular frame. (Berger and Mohr 69) **b** Black-and-white photograph of the woman who seems engaged in conversation with Sassall and holding two pieces of paper. The viewer can only see the back of Sassall's head. (Berger and Mohr 70) **c** Black-and-white photograph of the woman speaking to Sassall and rubbing her nose with her left hand. Again, the viewer can only see the back of Sassall's head. (Berger and Mohr 70) **d** Black-and-white photograph of the woman talking to Sassall, who is now standing again but the viewer can only see his right hand and his trousers at the left edge of the photo. She is still sitting, looking up at him and one of her palms is faced upwards in a gesture of inquiry or indignation. (Berger and Mohr 71) **e** Black-and-white photograph of the woman and Sassall, who is now sitting, and the viewer can only see the back of his head. The lady is hunched forward, presumably taking her seat again. She is laughing. (Berger and Mohr 71)

common experience, Berger disagrees: "they do not talk as equals." Even as he tries to be a part of their conversation, at the end of the day, Sassall is an intellectual with sophisticated ideas and manner of speaking: "He is privileged because of the way he can think and can talk!"

Also: “He is trusted. Yet this is not the same thing as saying that he is thought of or treated as an equal. It is evident to everybody that he is privileged” (101).

Sassall’s privilege – and by extension, the power he wields in his community – thus represent a problem for the practices of recognition that are such an important part of his pain-work. I follow Kelly Oliver’s argument (2015) that “in practice, recognition is experienced as conferred by the very groups and institutions responsible for withholding it in the first place” (474). The mutual recognition that enacts the identities of Sassall and his patients doesn’t always consider the difference in status between them. The master-slave dialectic, with its stipulation that the master needs the recognition of his slave, makes sense in theory. In practice, however, something must be added to recognition in order to mitigate the impasse presented by privilege and power. For Oliver, this can be done through “witnessing,” an ethos which I argue is central to Berger’s enactment of Sassall’s pain-work.

Witnessing “is a process of address and response that radicalizes Hegel’s insight that subjectivity is constituted intersubjectively” (Oliver 2015, 475). “Drawing on the double meaning of witnessing as both eyewitness testimony and bearing witness to what cannot be seen,” Oliver develops “a tension at the heart of subjectivity that opens up the possibility of considering both socio-political context, on the one hand, and the intersubjective constitution of subjectivity, on the other.” Witnessing therefore allows not just a consideration of subjectivity but also of “subject positions” (483) that are the result of political processes. Though Sassall’s pain-work must operate through a diffusion of the self toward the universal, it must also acknowledge the particularities of each patient’s subject position, much like the *punctum* of a photograph. Moreover, the double meaning of “witness” – eyewitness testimony and bearing witness to that which cannot be seen – introduces indeterminacy and complexity to the clinical encounter.

Oliver’s thinking on witnessing can be compared to such work as Giorgio Agamben’s *Remnants of Auschwitz* (1995) and Shoshana Felman and Dori Laub’s *Testimony* (1992), both having to do with how Holocaust survivors “bear witness” to the horrors of the Final Solution. But witnessing has also been used in less overtly political contexts, such as individual illnesses. In *The Wounded Storyteller* (1995), sociologist Arthur Frank writes: “The witness offers testimony to a truth that is generally unrecognized or suppressed. People who tell stories of illness are witnesses, turning illness into moral responsibility” (137). But even as Frank makes the patient or survivor of an illness the witness – the titular “wounded storyteller” – other scholars have also theorized the physician as witness. Rita Charon, the pioneer of “narrative medicine,” employs witnessing as a clinical practice. She writes:

> Self-knowledge, after all, is one of the goals or at least intermediates in any effort at health or wholeness. Ideally, the body and the self of the patient would be in easy communication, perhaps with the help of a mediator or interpreter. This is what seems to happen in a narrative medicine practice. The patient’s body talks with the patient’s self, in an odd and powerful way, while I, the witness, listen. (2009, 123)

Charon, like Oliver’s witness, “bears witness to what cannot be seen” – she listens while being there with the storyteller. The non-visual senses are of prime importance here. As Frank himself writes, the testimony of the illness witness is “less of seeing and more of being” (1995, 140), and that “the witness of suffering must be seen as a whole body, because embodiment is the essence of witness” (141). Even Barthes, when speaking of photography – an ostensibly visual medium – is interested not so much in what the camera sees but that the photographer was *there*, what he calls the latter’s “second sight”: “The photographer’s ‘second sight’ does not consist in ‘seeing’ but in

being there" (1981, 47). Mohr's photographs, supplementing Berger's writing and Sassall's practice, do not merely see but witness for posterity that these patients and their troubles existed. In these ways, the physician and the photographer, while still holding on to their visual expertise, code-switch to other embodied senses in order to serve as witnesses.[iii]

Dr. Sassall appears as "witness" in two moments of Berger's text. "The doctor is the familiar of death," Berger writes in one instance. "When we call for a doctor, we are asking him to cure us and to relieve our suffering, but if he cannot cure us, we are also asking him to witness our dying. The value of the witness is that he has seen so many others die… He is the living intermediary between us and the multitudinous dead" (68). Here, the physician as witness to death ties in again with the photographer's witness. For Barthes, a second *punctum* in photographs, "is Time, the lacerating emphasis of the *noeme* ('*that-has-been*'), its pure representation." He explains further: "It is because each photograph always contains this imperious sign of my future death that each one, however attached it seems to be to the excited world of the living, challenges each of us, one by one, outside of any generality (but not outside of any transcendence)" (97). Part and parcel of both the physician's and photographer's – and one could argue even the sociologist's – pain-work is the realization that the person being treated, photographed, or written about will die at some point. The "future death" of the subject is therefore the sine qua non of witnessing and pain-work, a *punctum* that resists generalization and further individualizes the subject. The notion of "future death" is particularly significant when considering *A Fortunate Man*, given that Dr. Sassall died by suicide a few years after the book's publication. Knowing this when reading the text and viewing the photographs gives the book's witnessing an added urgency.

Witnessing appears at another moment in the text: "[Sassall] does more than treat [his patients] when they are ill; he is the objective witness of their lives… He is qualified to be this precisely because of his privilege" (109). Sassall remains, because of his relative privilege, an outsider to the community he treats, and Berger and Mohr are even further removed and privileged compared to Sassall and the Forest of Dean, being famous, cosmopolitan outsiders and intellectuals. There is a paradox inherent to being an objective witness on the one hand and privileged (therefore, powerful) on the other. Can a powerful witness be truly objective? After all, isn't "objectivity," at least as it was formulated in the nineteenth century according to Daston and Galison – what they call mechanical objectivity – to "let nature speak for itself" (2007, 120)? Does not a person's power influence the putative objectivity of their gaze? Perhaps, and Berger recognizes this, which is why he refers to Sassall as the "clerk of [his patients'] records." This mode of objectivity isn't necessarily that of the all-seeing eye from above which can reproduce nature exactly on the page; as Berger writes, Sassall "is not the representative of an all-knowing, all-powerful being."

Being a clerk involves organizing, collating, and curating records. Daston and Galison would call Sassall's work an outcome not of an objectivity which presumes to know everything about everyone, but of "trained judgment," that ethos developed in the sciences in the mid-twentieth century which saw the limitations of mechanical objectivity and sought to reinterpret images and classify them through intuition. Sassall's is a humbler objectivity of using his privilege and intuition to record, listen, and be with his patients. Berger and Mohr in turn mimic this ethos; they too are clerks of the records of the Forest of Dean. *A Fortunate Man* becomes not an exhaustive key to the lives and deaths of a rural community, shorn of the imprint of its makers, but a repository of text and images curated through trained judgment. Objectivity has its place in this work, but it is tempered with the interlaced subjectivities of Sassall, Berger, and Mohr. It is a compendium of doctored images.

## Conclusion: the modest witness and pain-work

It is worthwhile to situate Sassall's witnessing within Berger's larger oeuvre and within the global political crises at the time that *A Fortunate Man* was published in 1967. The Vietnam War was in full swing, and much of the work on witnessing and photography was addressed to such mass atrocities. After having published *Ways of Seeing* (1972), Berger published *About Looking* (1980), the latter essay collection preoccupied with the politics of beholding the countless photographs of war, devastation and suffering that were circulating at the time of its writing. In one essay titled, "The Uses of Photography" (1978), he bemoans how the camera in the latter half of the twentieth century has turned everything into a "spectacle" (Berger 1980, 55), and how it offers "information severed from all lived experience" (52). It is notable then that the way Berger and Mohr enact Sassall's being "fortunate" is by placing the Forest of Dean in comparison with the troubled regions of the world. At one point Berger mentions how "the Vietnamese villages are burned alive though nine-tenths of the world condemns the crime" (1967, 134).

Sassall can claim that the foresters of Dean are fortunate compared to the Vietnamese, but "he knows that the foresters are in almost all respects unfortunate compared to what they could be – given better education, better social services, better employment, better cultural opportunities, etc." (135). What Berger and Mohr undertake here, as opposed to the spectacularized witnessing of war photojournalism, is a kind of "modest witnessing," of everyday lives and deaths. Historians of science Schaffer and Shapin coined the term, "modest witness," in their book *Leviathan and the Air-Pump* (1985) to refer to the "gentleman-scientist" of the Enlightenment who must circulate his scientific findings in a "modest" manner, without hyperbole, so that the public can believe his data and conclusions. While scholars like Donna Haraway (1997) have rightly critiqued this version of the scientist as masculinist and exclusive of other identities, Sassall seems to embody a version of the modest witness engaged in pain-work. While the modest witness of the Enlightenment would have relied primarily on the visual modalities of the eye and mechanical objectivity, modest witnesses like Sassall use trained judgment and multisensory modes of witness: being, listening, touch, and crying. He is a modest witness of his patients' lives. To witness in pain-work then is not to give testimony to mass suffering but to bear witness to the mundane, individual sufferings.[iv]

Susan Sontag wrote in *Regarding the Pain of Others* that "the sufferings most often deemed worthy of representation are those understood to be the product of wrath, divine or human…Suffering from natural causes, such as illness or childbirth, is scantily represented in the history of art" (2003, 33). Barthes has an adjacent point about where we can find *punctum*. He writes that journalistic photographs about war and catastrophe necessarily become part of the cultural milieu, so that one must look at them as par for the course. "These journalistic photographs are received (all at once)," he writes, "perceived. I glance through them, I don't recall them; no detail (in some corner) ever interrupts my reading: I am interested in them (as I am interested in the world), I do not love them" (1981, 41). These is no *punctum* in these images because, for Barthes, their literal violence can "shout" but not "wound." It was perhaps imperative, then, for Berger and Mohr to represent in a time of worldwide catastrophe the illnesses of people in an obscure English village and the physician who addressed them. They enact the people, the countryside, and Sassall by

representing the practices that constitute them. And what this enactment shows is that Sassall's clinical practice goes beyond a disembodied gazing of his patients. Instead, it performs pain-work, a combination of recognition and witnessing which, through intersubjectivity, aligns vision with embodied cognition.

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## Endnotes

[1] It is important to note that Foucault's study is limited to eighteenth and early nineteenth centuries. For studies of ocularcentrism in medicine beyond Foucault and as it relates to visual technologies of the late nineteenth and twentieth centuries, see Lisa Cartwright's *Screening the Body: Tracing Medicine's Visual Culture* (1995), in which she analyzes how the visual technology of cinema was used in medicine to "analyze, regulate, and reconfigure the transient, uncontrollable field of the body" (xiii). For a less theoretical and more conventionally historical examination of vision and medical technology, see Stanley Reiser's *Medicine and the Reign of Technology* (1978) which follows the development of medical technology from the seventeenth century to twentieth. He argues that with the invention of the ophthalmoscope, laryngoscope, and X-ray toward the end of the nineteenth century, physicians began to consider vision as superior to the other senses for diagnostic purposes. One physician concluded that medicine was "gradually relegating hearing to a lower intellectual plane than sight" (quoted in Reiser, 68).

[2] Also see Oliver's engagement with vision in her earlier work, *Witnessing: Beyond Recognition* (2001). She argues that so much of both the defense and denigration of vision in Western philosophy is predicated on a false presumption of vision as "distance," i.e. that in order to recognize objects properly we must place them at a certain length from our eyes. This notion is in turn based on another faulty assumption: that the distance between the beholder and the beheld is empty space. Using psychologist J. J. Gibson's notion of "ecological optics" and philosopher Merleau-Ponty's phenomenology of perception, Oliver argues that spatial distance, replete with vibrations, photons, energies, is in fact "thick with the flesh of the world" (201), making our selves continuous with others'. This would seem to suggest that Sassall's clinical gaze is not "detached" but of a piece with the subjectivities of his patients, the result of "touching eyes" (198) which do not merely see but feel the pain of his patients. This is also similar to Barthes's point about the rays of the photographed body touching him.

[3] Also see Donna McCormack's *Queer Postcolonial Narratives and the Ethics of Witnessing* (2014), in which she argues that the privileging of vision above the other senses is in fact a typically colonial attitude, and she advocates for a witnessing that uses "multisensory epistemologies" (27).

[4] Anthropologists such as Peter Redfield have employed the term modest witness to examine the activities of doctors in medical humanitarian organizations like Medicin Sans Frontieres (MSF), or Doctors Without Borders, who enshrine the practice of témoignage (witnessing, outspoken advocacy for oppressed peoples) in their charter. In one article, "A less modest witness" (2006) he argues that the modest testimony of the gentleman-scientist undergoes a shift toward collective advocacy in organizations like MSF. The physician in MSF combines technical expertise with public testimony to produce matters of fact as matters of ethical concern and vice versa. Redfield terms this unexpected phenomenon "'motivated truth' to highlight the overt combination of reason and sentiment that it represents" (2006, 5). Physicians like Sassall not on the frontlines in conflict zones but in less visible, "unfortunate" places seem to enact a similar ethic of "motivated truth" through pain-work.

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