This section features original work on pathographies—i.e., (auto)biographical accounts of disease, illness, and disability—that provide narrative inquiry relating to the personal, existential, psychological, social, cultural, spiritual, political, and moral meanings of individual experience. Editors are: Nathan Carlin and Therese Jones. For submissions, contact Nathan Carlin at: Nathan.Carlin@uth.tmc.edu.

My Unexpected Journey from Medication to Meditation

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"Maybe you should try meditation." I wanted to slap my psychiatrist when those words came out of his mouth. I was 20 years old at the time and had spent the last 12 months suffering—both physically and emotionally—through what seemed like a cruel experiment. That year, I had been cycling through numerous cocktails of antidepressants, mood stabilizers, and antipsychotics[1] to treat a misdiagnosed case of bipolar disorder when I was, in fact, experiencing a deep depression brought on by a recent family trauma.

The medication led to an array of unfortunate side effects, causing me to feel completely disconnected from people, as though I were in a bubble. I was so drowsy and unfocused that I was too scared to drive; I began to lactate (perhaps the most traumatic symptom for a young woman); and there are still some gaps in my memory. The final straw was when I got on the subway headed to college one morning only to find myself in the midst of a medication-induced hallucination, with the floor of the station and the train appearing to shift beneath my feet. I managed to make it to my stop and take the escalator up to the outside world, where I slumped down on the sidewalk, leaned against a wall, and burst into tears, hysterical.

This was not the first time I had found myself hysterical in response to a recently prescribed medication, or to the confusing circumstances of my life. I had already been marked as the female hysteric who had contacted her psychiatrist in a panic too many times, who had been informed that he would no longer take her calls.

And so I found myself once again sitting across from the psychiatrist who had refused my calls, this time resolved that I was done with his recommendations, that I couldn't do this to myself anymore, that I wouldn't let him do this to me anymore. Each adverse reaction had felt like a violation of my mind and body, and I blamed him.

At the time, I did not understand that my frustration was just another manifestation of the historically complex and gendered relationship between a female patient and a male physician authoritatively wielding his medical gaze. This gaze, most famously noted by French

Cambridge Quarterly of Healthcare Ethics (2018), **27**, 732–737.

doi:10.1017/S0963180118000221

philosopher Michel Foucault, arose out of the scientific professionalization of medicine in the nineteenth century. The physician then emerged as an expert with a discerning eye, no longer trusting the words of a patient to understand his/her ailment. He turned instead to the body to disclose its secrets, following the dictum that "if one wishes to know the illness from which [the patient] is suffering, one must subtract the individual, with his particular qualities."[2] My particular qualities—how I perceived, understood, and articulated my unstable mental state—were unreliable when compared to what my body revealed in spite of myself.

What my body revealed most starkly was that I, at 19 years of age, had decided to cut myself. For my psychiatrist, this physical marker translated most reliably as a symptom of bipolar disorder, a translation facilitated by and verifying the predetermined psychiatric worldview characterizing his exacting gaze. For "in order to know, he [recognized], while already being in possession of the knowledge that [lent] support to his recognition."[3] It was a recognition that revealed me as someone afflicted by a medical disorder, therefore requiring medication.

What struck me most—in fact, what upset me even more than the side effects of the medications—was that our two worldviews were so dissimilar. He brought with him an expertise that prepositioned those entering his office within the framework of psychiatric medicine. That, after all, was the job he held and had trained for. I, by contrast, only brought with me personal knowledge of what I sensed and felt through my body and mind. His outlook was so certain and decisive, so quick to offer one pill to replace another, whereas mine was utterly confused and disorderly.

I was all too aware of my embodied experiences: complicated sensory reactions to medications enmeshed with cognitive and emotional responses such as sadness, surprise, and fear. But I was without a vocabulary to understand these in a context other than embarrassment and horror. My psychiatrist's refusal to receive my calls had told me that how I sensed and expressed my own distress were not to be trusted or even worth hearing. It became clear that he, not I, was the expert in my mental condition.

At the time, I wanted him to understand and even empathize with how tormented I was, not just by his mode of treatment, but also by the inequitable nature of our relationship, as well as by the larger institutional and professional apparatus that facilitated our unequal dynamic. I wanted him to explain it to me. And although I did not know then exactly what I was asking, perhaps he knew in the moment when he suggested meditation that I desperately needed something neither he nor pills could give me. So it makes sense, in retrospect, that he suggested that I seek to make a refuge of my own mind.

Discovering the Medical Humanities

In many ways, I have spent the last 11 years in academia making sense of this earlier experience. At, 20, I knew that I wanted to go to graduate school to cultivate my literary interests. But I now also wanted to study how health institutions worked, how decisions about diagnosis and treatment were made and, especially, how doctors made sense of their own practices. To understand my experience, I needed to understand my psychiatrist's.

In graduate school, I researched present tendencies in the medical profession by exploring its past, reading historical medical texts alongside literary works. In this way, I learned about the foundations of the medical profession and how

it simultaneously influenced and was influenced by the public imagination and popular culture. Before I knew it, my research project transcended both my own trauma and my focus on the discipline of psychiatry. My dissertation centered instead on professional and popular writings by doctors (all men) acclaimed for their integral role in the formation and professionalization of medicine as a science. However, I did not focus on their acclaim, but rather on how each made sense of and related to his work, and how each negotiated his own mind and body as he grappled with the demands and responsibilities of healing.

The questions I found myself asking and attempting to answer led me to medical humanities, a field that undoes the categorical divisions between medicine and the humanities as hard versus soft, objective versus subjective. I could see past the enclosed black box of medicine into a more personal and subjective realm of science—a realm of intuition, indecision, judgment, and even sentiment—integral to grasping the full scope of the discipline/practice. I was finally able to recognize my college psychiatrist as profoundly human.

What is it to be human in medicine? Often one conjures an image of the afflicted, suffering humanity of a patient and the benevolent humanity of a doctor who has undertaken the burdensome task of treating illness. Perhaps a Thomas Eakins painting comes to mind.[4] But neither patient nor doctor exists in a vacuum. Each has made his or her way onto the medical scene bearing social expectations, preconceptions, and value judgments.

The patient arrives in anticipation that the medical establishment will decipher the enigma of illness and offer a cure. The strength of the patient's conviction in the capacity of the institution or clinician is likely shaped by popular opinion, prior experiences, or the recounted experiences of others. The doctor has likewise come to medicine with his or her own personal encounters and preconceived notions of what the work will be like (perhaps inspired by medical dramas on TV such as *Grey's Anatomy*, as some of my students are). Once within the medical establishment, however, a doctor must bear the responsibility of attending to a patient while trying to manage the grueling demands of a curriculum and clinical practice that privileges technological advances and the memorization of facts over the human aspects of caregiving. This long-observed dynamic within medicine discounts and undervalues the lived experiences of both the healer and the person who is to be healed as sensing-feeling individuals.[5]

What does it mean to experience medicine? As I struggled to realize and justify the significance of my lived experience within the psychiatric framework, I discovered that the word "experience" itself encapsulates the tension between the perceived tidy neutrality of science and the messy temperamentality of the personal. The English term derives from "expérience" in French and "experientia" in Latin, with both referring to one's awareness as the subject of a state or condition: the mode we usually think of as *our experience*. What one does not think of, however, is that these words also signify experimentation in the acquisition of observable, empirical knowledge. Experience accordingly entails a state of being in the world that is simultaneously subjective and objective. Etymologically speaking then, one cannot acquire the disinterested guise of scientific (and in this case medical) inquiry without being affected by the vagaries of personality.

Recognition of this confluence of subjectivity and objectivity resides at the core of medical humanities. One's encounters with and within the dynamic healthcare establishment—composed

of its bodies, spaces, instruments, ideologies, methodologies, knowledge, and professional codes of conduct—are mediated through one's sensations, insights, ideas, aspirations, and sentiments.

The Bias of Objectivity

Too often, we think that scientific practice operates solely through the logic of the body as a sensory mechanism, a nonthinking, nonfeeling receptacle of pure sensation. The scientific method, after all, relies on physiological sense perception as its chief mode of acquiring evidence and determining facts. "To be objective," historians of science Lorraine Daston and Peter Galison assert, "is to aspire to knowledge that bears no trace of the knower—knowledge unmarked by prejudice or skill, fantasy or judgment, wishing or striving."[6] It follows that the truly scientific self must be free of subjectivity. One's ability to embody such an idealized objectivity determines how scientific knowledge is created and even what counts as scientific knowledge.

The turn to such an objectivity, along with its ideal erasure of subjectivity, was a product of scientific advancement in the nineteenth century. Not surprisingly, in the realm of medicine, its establishment coincided with the development of the medical gaze. This selfless gaze, however, aspires to do more than inhibit the individuality of the doctor using it; it also aims to depersonalize the patient. The ideal medical encounter, it would seem, does not take place between doctor and patient. It takes place between the scientific eye and illness itself.

But even the endeavor to efface one's subjective self, Daston and Galison point out, requires the determination (what they refer to as a "willful self") to do the effacing. One must enact, monitor, and maintain the absence of subjectivity. And in order to do so, one must be properly educated and trained. Objectivity as a practice is to be fashioned through individual will, capability, and expertise. It cannot be pure "blind sight, seeing without interference, interpretation or intelligence."[7] It operates at best as an aspiration and a negotiation with the ideal. To set up a hierarchy of objective and subjective, where the former is a virtue and the latter a vice, is to set up an impossible task. This is not to say that the discovered facts of science and medicine should be altogether challenged; it is to stress that there is more nuance to the discovery of facts, which includes the individual doing the discovering.

To envision the practice of medicine as one untainted by subjectivity, as though neither doctor nor patient lived in or was impacted by the world, is to ignore the reality of the human condition. Giving up this penchant for objectivity (dare we call it a bias?) would require us to be mindful that we cannot, in fact, give up living in the world. It would also mean acknowledging our other proclivities: those prejudices that stem, unbeknownst to us, from our politics, economic status, cultural background, religious beliefs, gender, and education. But it is only when we confront and understand the full range of our experiences that we can correct for our value-laden sensibilities and successfully negotiate with the value-free aspirations of diagnosis and cure.

Medicine, Mindfulness, and Meditation

As I have come to terms with or, put differently, as I have researched, historicized, and philosophized (like a good academic) the dynamic constituents—participants, institutions, and ideologies—that came together to compose my encounters with psychiatry in college, I find I have gained a deep empathy for those engaged in the practice of medicine. This science, after

all, aims to gaze and decipher objectively while being continuously confronted with the starkest aspects of humanity: disease, aging, and death.

I have also gained a deep appreciation for the need to attend to one's immediate, embodied experiences as a means of gaining knowledge about the world. The words of Maurice Merleau-Ponty, another French philosopher, speak most to me: "I do not see [space] according to its exterior envelope; I live it from the inside; I am immersed in it. After all, the world is around me, not in front of me."[8] When I first read those lines, it dawned on me how self-centered we all are; each of us is literally situated at the center of our own world. We cannot help but sense and perceive from a perspective that is entirely personal.

Ironically, being mindful of my susceptibilities has led me down the exact path suggested by my college psychiatrist: meditation. In particular, vipassana (usually translated as "insight" or "mindfulness") meditation has enabled me to experience how I am truly immersed in the world, how I live it from the inside. This practice teaches that "breath is the bridge which connects life to consciousness, which unites your body to your thoughts."[9] Focusing on my breath, whether in line at the grocery store or on my meditation cushion at home, has led me to understand the convergence of physical sense perception and contemplative self-perception recognized as my person. Anxiety feels like a sustained rushing jitteriness all over (not unlike excitement though less pleasant); depression is accompanied with the sensations of a large open gash or wound at my chest.

To really know the world around me at any given moment requires me to know myself in that moment, to open myself to the complexities of its experience. I must not only observe but also make an effort to comprehend what and how I feel physically, emotionally, and cognitively. Mindfulness then facilitates a less reactive, more thoughtful, more measured—and dare I say more objective—response to any situation. It also cultivates compassion for myself and others, each of us caught in the tangled webs of our experiences.

Despite my unfortunate encounter with psychiatric treatment in college, I have been able to make a more insightful and agreeable return to it and to antidepressants. Although a part of me still harbors resentment toward the psychiatrist who unwittingly set me on this journey, I understand now that he was only attempting to help in the way that he knew best. But when medicine failed me (and him), he was able to set aside science, logic, bias, and years of schooling to propose I try a centuries-old Eastern practice instead. Because he thought it might help me. It was a sensitive, undeniably human thing to do.

Notes

1. I remember there being at least nine medications, although all their names escape me. The ones I do remember include Resperdal, Seroquel, Lamictal, Wellbutrin, Buspar, and Lexapro.
2. Foucault M. *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Pantheon Books; 1973, at 14.
3. See note 2, Foucault 1973, at 9.
4. American realist painter Thomas Eakins (1844–1916) is perhaps most famous for his depictions of medical practice, in particular the anatomy lecture. See *The Gross Clinic* (1875) and *The Agnew Clinic* (1889).
5. Here are just a few examples of the extensive literature on the role and decline of empathy in medicine: Lee TH. *An Epidemic of Empathy in Healthcare: How to Deliver Compassionate, Connected Patient Care That Creates a Competitive Advantage*. Columbus, OH: McGraw Hill; 2016; Halpern J. *From Detached Concern to Empathy: Humanizing Medicine*. Oxford: Oxford University Press; 2011; Spiro HM, McCrea Curnen MG, Peschel E, St. James D. *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*. New Haven: Yale University Press; 1996.

6. Daston L, Galison P: *Objectivity*. New York: Zone Books; 2007, at 17.
7. See note 6, Daston, Galison 2007, at 17.
8. Merleau-Ponty M. Eye and mind. In: *The Primacy of Perception*. Edie JE, ed. Dallery C, trans. Evanston, IL: Northwestern University Press; 1964, at 178. Merleau-Ponty's specific philosophy, called "phenomenology," foregrounds direct experiential contact in the study of an object and its deeper meaning.
9. Naht Hahn T. *The Miracle of Mindfulness: An Introduction to the Practice of Meditation*. Boston: Beacon Press; 1975, at 15.