

A MILLION STREAMS: TMC Arts Intersecting Medicine Council Lecture

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I. A million streams of data

Take a moment with me to imagine a single aspect of the immensity of the Texas Medical Center. The TMC includes 50 million square feet of developed space. Given that contemporary hospitals average four feet of wiring for every square foot of developed space, that means 200 million feet of wiring. To use that old cliché, beneath our feet and all around us is enough wire to circle the globe at the equator and make it half way around again. But of course it isn't strung together in a single line. The wire is connected in profoundly complicated networks within and without the Texas Medical Center – within and between the partner institutions sitting here today. All I want us to do as we begin is hold that image – however it looks to you – in our awareness. Imagine all the hidden copper and glass fiber, the rubber insulation. All that electrical current, all that binary language, the ones and zeros flowing endlessly, in discrete packets, beyond our everyday awareness. Imagine all the points of divergence and connection. All the intersections.

Imagine with me for the next ten minutes about what it means to be a human being in this space. When you enter the Texas Medical Center, you are engaged in the most extraordinary mobilization of the healing desire and intention of the human being in history. I really don't think that's an exaggeration. We're used to hearing hyperbole about this campus, but we are standing in a truly unprecedented human endeavor.

As a psychotherapist, I'm interested in what we don't see. What is humming, quietly, powerfully, below the surface, behind the walls. You don't have to have any background in psychology to understand intuitively that every surface hides a depth. Behind the clean, sterile surfaces of the examination rooms, the operating theaters, the customer service spaces, the accounting offices, is a complex network of wires, cables, ventilation ducts, oxygen lines, security cameras, fire systems. And also some fundamental assumptions about what the human being needs and can find in these spaces.

The French philosopher and historian Michel Foucault suggested that in the 19th century there emerged what he called the clinical or medical gaze. The clinical gaze is a specific way of seeing the human being that privileges observation rather than theory or the imagination. We use our senses to apprehend and measure the phenomenon before us. This gaze emerged for good reason, and its effects have been extraordinary. In the last century in the United States, the human lifespan at

birth has soared – from 49 and 34 years for white and black women, respectively, to 80 and 75 years. The advance in medicine is one of the key factors in this change.

For those of you unfamiliar with Foucault's work, he was interested in the ways that invisible dynamics of power shape our lives. I promise that I'm not going to spend more than another minute talking about French philosophy, which I'm not qualified to do in any case. But his perspective on the emergence of contemporary medicine is vitally important for us to understand why art needs to intersect medicine. The story we tell ourselves about contemporary medicine is that scientist/physicians passively receive the data of their senses, aided by increasingly sophisticated technology, to intervene in healing ways. What Foucault understood is that observation is far from passive or unbiased, and that this particular kind of observation serves and is driven by forces outside of the observer's awareness. He also understood that when we observe, we actually construct. Observation is a creative act. Here in the Texas Medical Center, we build a vision of the human being that is a body composed of a million streams of data. That human being is subject to the powers that control and benefit from the particular streams of data that are prized by the clinical gaze.

Which leads us back to what lies behind the walls of the Texas Medical Center—and what hides in plain sight. When we enter an examination room, we see crisp lines, bright light, clean white paper, sinks and discreet biohazard garbage bins. The technology of observation is present but unobtrusive. When we encounter the medical staff, we are reassured by their white coats, their colorful, utilitarian, and uniform scrubs, their friendly, brisk interrogations. These are ritualized engagements. We know that our vital signs will be taken – measurements that add to the streams of data already flowing through our charts. Our conversations are rote, repetitious, highly structured, with a veneer of intimacy. We may share with our medical staff fundamental experiences we do not share with our loved ones. The clinical gaze sees all – or so we hope and imagine.

What lies behind the walls are the beds of these streams of data, the electricity that powers their accumulation and transmission. Where they flow, we truly do not know. We have faith, usually substantiated, that the streams of data flow at least towards a resolution of our suffering. I do not mean to imply that they also flow to problematic destinations. Just that we simply do not know where they go.

II. Minding the gaps

I have been using the image of a stream to describe the creation of data in this process. Reflect for a moment about what that image suggests: water, nature,

gravity, continuity, perhaps peace. The actual process of creating data in the clinic varies depending on the kind of data. But at the level of the specific observation, the observations as a whole, even the way the data is transmitted in a series of ones and zeroes, we can see important differences.

The process of creating a CT scan involves taking scores of X-ray pictures of an area of the human body, progressive slices of a flat plane across a specific axis. It gives us an impression of the whole using discrete parts. But of course, it isn't an impression of the whole of a human being – just the whole of a part we have separated from the rest of the whole human body. The clinical gaze necessarily creates a series of images of parts of the whole. It is not a stream, because there are gaps.

There are gaps too between the different modes of observation, the different sets of data collected. The data sets do not add up to a human body, let alone a human being. Nor should they, necessarily. What I'm interested in is the way we expect them to, and how we unconsciously fail to notice that they do not. When we enter an examination room, the necessary narrowness of the clinical gaze cannot help but change us. Suddenly the phenomena made visible by this specific and powerful kind of observation take a much greater place in our imaginations.

I have hypertension. Along with medication, the diagnosis comes with a set of narrative arcs, of images. I imagine future strokes. Lots of exercise. Less salt. The bodies and patterns of my parents and my siblings. Perhaps even moral failure or redemption. The ways we adhere to a treatment plan – or don't – are charged with emotion and judged by ourselves and others. Hypertension is also a remarkable metaphor for a condition of life. The level of tension in my life is too great. And it is a kind of identity. I am hypertensive. Can you hear how the imagination responds to the clinical gaze?

Contemporary medicine is itself a profound work of the creative imagination. Why does art need to intersect medicine? Because of the gaps. Because the individual human being is much more than streams of data. Because the life-sustaining power of medicine irrevocably alters how we understand ourselves, often in ways that are unintended and unexamined.

III. Imagining the intersection of art and medicine

Since I'm here representing The Jung Center, I want to briefly bring C.G. Jung into the room. For those of you who are not familiar with him, Jung was a Swiss psychiatrist who was born in the nineteenth century and died more than halfway through the 20th. He is known for his stormy relationship with Sigmund Freud, his

interest in dreams, his personality theory (that is the basis of the Myers-Briggs Personality Inventory), his innovations in cultural psychology and gender theory, and his desire to understand religion and spirituality from a psychological perspective.

Above all, he understood that the imagination is inextricable from human experience. It is experience itself. He wrote that “...every psychic process is an image and an imagining, otherwise no consciousness could exist and the occurrence would lack phenomenality.” In order to have a phenomenon, we have to have an image of it.

We are our images, and they are us. Before it was constructed, this room was imagined. Each of the techniques used in the clinical spaces of the TMC was imagined. So was all of the equipment the staff uses, the accounting and billing procedures, the complex data infrastructures, the management strategies. Each one of us called into the Texas Medical Center – patients, staff, students, vendors, chaplains, visitors – imagines what called us here. What we want from the experience. What meaning it generates in our life.

Modern medicine needs art to make it conscious of itself as a titanic engine of the human imagination. When we step into this engine, we need art to remind us that the engine serves us, and we do not have to be remade in its image. Art expresses the boundless complexity and possibility of an individual human being, which far exceeds the clinical gaze. We are more than bodies, more than data sets. And art can be a powerful ally to the healing process precisely because it allows access to what is not observable, not measurable: the profound mystery of the human psyche at work. Many times in my clinical work, I have been privileged to see new life emerging in the expressive art of a client. Creativity is a fundamental human need no matter how old you are, no matter whether what you create can be sold in a gallery, a concert hall, or a bookstore. It creates intersections. It brings meaning into life. It overflows the gaps.

References

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