Beyond the Clinical Gaze: Death, Care, and Physician Identity in Anna DeForest's Our Long Marvelous Dying

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***Abstract*—Medicine is conventionally narrated as a science of diagnosis and cure, yet those who practice it spend much of their working lives in the presence of suffering, mortality and loss that no treatment can reverse. This paper reads Anna DeForest's novel Our Long Marvelous Dying (2024) as a literary record of the physician's experience in the space between life and death. The novel follows an unnamed narrator, a physician undertaking a fellowship in palliative care during and after the Covid-19 pandemic, as she cares for dying patients and their families while confronting the death of her long-estranged father and the strains of her own marriage and family life. Drawing on medical humanities, narrative medicine, the sociology of death and dying, and theories of liminality and care ethics, the paper argues that the novel presents the hospital as a liminal space in which life and death coexist; portrays the physician as a vulnerable subject who bears emotional and moral burdens rather than a detached technical expert; locates healing in presence, listening and honest communication when cure is no longer possible; and uses an auto fictional, fragmentary and lyrical form as an ethical response to the limits of clinical language. The paper concludes that the novel enlarges the aims of medicine from curing disease to accompanying persons through suffering with dignity, and that its insights are relevant to medical education and to the care of caregivers after the pandemic.**

***Index Terms*—Death, Dying, Medical humanities, Narrative medicine, Palliative care, and Physician experience.**

I. INTRODUCTION

Physicians are trained to diagnose, treat, prevent disease and take ethical responsibility for the health of individuals and communities. The public image of the physician tends to stop there: a figure of competence and authority. The humanities have long complicated that image by insisting that doctors are also human beings who feel fear, grief, guilt and fatigue, and who meet ethical dilemmas that protocols cannot settle (Charon; Halpern; Ofri). The doctor–patient relationship, the emotional burden of clinical work and the moral weight of decisions at the end of life are therefore not peripheral matters but central to what medicine is.

The twenty-first-century pandemic made this insight impossible to ignore. Hospitals became places where clinicians worked at great personal risk, witnessed death in unprecedented concentration, made rationing and triage decisions under pressure, and in many cases fell ill or died themselves. Research on healthcare workers during Covid-19 documented anxiety, exhaustion, burnout and moral injury (Greenberg et al.). In this climate, literature that renders the physician's inner life takes on new urgency.

Anna DeForest, a physician trained in neurology and palliative care and an MFA-trained writer, is one of the more distinctive voices in this field. Her second novel, Our Long Marvelous Dying (Little, Brown), is set in the world of end-of-life care in the shadow of the pandemic. It does not offer a heroic account of medicine. It offers a spare, lyrical and often darkly humorous meditation on dying, on the people who attend the dying, and on how those people live, or fail to live, when the work is done.

This paper asks: How does Our Long Marvelous Dying represent the physician's experience between

life and death, and what does that representation contribute to the medical humanities? It proceeds by outlining the conceptual framework, introducing the author and the text, analyzing six thematic strands of the novel, and discussing implications for medical education and practice.

II. CONCEPTUAL FRAMEWORK

The medical humanities took shape in the United States and the United Kingdom in the 1960s and 1970s as a movement to bring literature, philosophy, ethics, history and the arts into medical education and practice. Its aim was to cultivate empathy, ethical reflection and an understanding of the human experience of illness alongside biomedical competence (Cole, Carlin and Carson; Bleakley). Later work widened the field into the "health humanities," attending to patients, families and caregivers as well as clinicians (Jones, Wear and Friedman). Its recurring concerns are the doctor–patient relationship, ethics in practice, narratives of illness and suffering, and the emotional and psychological life of both physicians and patients. These are the concerns that structure the present reading.

Arthur Kleinman's (1988) distinction between disease, the biological malfunction the clinician identifies, and illness, the lived experience of the person who suffers, established that medicine must interpret meaning as well as pathology. Rita Charon extended this into narrative medicine, arguing that clinicians need "narrative competence": the ability to absorb, interpret and respond to the stories of illness. Arthur Frank described three broad illness narratives, restitution, chaos and quest, and showed that many stories of serious illness resist the restitution plot of recovery. Kathryn Montgomery Hunter (1991; Montgomery) showed that clinical knowledge is itself narratively structured: the case history is a story with conventions that include and exclude. DeForest's debut novel takes its title from one such convention, the "history of present illness," and her second novel continues the interrogation of clinical genres.

Medical training has historically valued "detached concern," a balance of compassion and emotional distance (Lief and Fox). Halpern argues that this ideal can harden into emotional isolation and proposes empathy as a more honest basis for clinical practice. Ofri documents how fear, anger, shame and grief shape clinical decisions. Maslach and Jackson defined burnout as emotional exhaustion, depersonalization and reduced sense of accomplishment; Shanafelt et al. showed its prevalence among physicians. The concept of moral injury, originally developed in relation to war (Litz et al.), has been applied to clinicians who must act, or fail to act, against their own moral expectations, and Rushton, Kaszniak and Halifax (2013) offer a framework for moral distress specifically among palliative care clinicians. Greenberg et al. applied these ideas to healthcare workers in the Covid-19 pandemic.

Philippe Ariès traced how Western societies moved from "tamed" death at home to a death hidden away and managed in institutions. Elisabeth Kübler-Ross and Sherwin Nuland brought the dying process into public discussion, and Atul Gawande criticized the medicalization of dying and argued that medicine's goals must include what matters to people at the end of life. Eric Cassell argued that suffering belongs to persons, not merely to bodies, and that medicine fails when it treats the body while ignoring the person. Ernest Becker saw the denial of death as a pervasive structure of human culture, and Freud theorized a tension between drives toward life and toward dissolution. Arnold van Gennep and Victor Turner described rites of passage and the "betwixt and between" condition of liminality, in which persons are neither what they were nor yet what they will become. The hospital ward in which patients move toward death, and in which clinicians and families accompany them, is a modern liminal space.

Care ethics treats care as a moral practice grounded in relationship (Noddings; Tronto). Tronto distinguishes attentiveness, responsibility, competence and responsiveness as phases of care. Judith Butler argues that shared bodily vulnerability and the "grievability" of lives are basic to ethical life, a view that illuminates the pandemic's exposure of human precarity. Emmanuel Levinas grounds ethics in the face-to-face encounter with the other. Against these, Michel Foucault describes the "clinical gaze," which constitutes the patient as an object of knowledge, and Julia Kristeva describes the corpse as the supreme instance of the abject, that which disturbs identity and order. Together these frameworks offer vocabulary for reading a novel in which clinicians look at, touch and speak about the dying and the dead.

III. METHODOLOGY

The study is a qualitative, interpretive literary analysis. It uses close reading of the novel's themes, narrative situation and form, read through the conceptual lenses above. The primary text is Our Long Marvelous Dying (DeForest), with DeForest's earlier novel A History of Present Illness (2022) consulted for context. Secondary sources include published reviews of the novel and scholarship in medical humanities, narrative medicine, death studies and ethics. The analysis is thematic: recurring concerns were identified and grouped into the six strands treated in Section 5. Because the narrator is unnamed and the novel blends memoir-like reflection with fiction, the paper refers to "the narrator" and treats her as a literary construct, while acknowledging the author's professional experience as a palliative care physician.

IV. PHYSICIAN VULNERABILITY AND EMOTIONAL STRUGGLES

In the novel the hospital is not merely a setting but a threshold. Patients arrive between recovery and death; families wait between hope and mourning; and clinicians stand between the biomedical project of keeping bodies alive and the human task of letting persons die well. This is the structure van Gennep and Turner describe: separation from ordinary status, a suspended middle phase, and a future incorporation into a new state. What is distinctive in DeForest is that the suspended middle is also a moral and emotional condition of the physician, who lives in this threshold daily and is changed by it.

The title itself carries the idea. "Long" and "marvelous" sit beside "dying," refusing both the euphemism that hides death and the horror that flees it. Dying is presented not as an instant but as a prolonged process that everyone is already inside, an idea consistent with Ariès's (1981) account of death as something modern societies have tried to confine to institutions, and with Becker's (1973) argument that culture is largely a defence against knowing it. The novel's publisher framing of a meditation on the twin drives of life and death echoes Freud's (1920/1955) polarity, but the narrative's texture is clinical and domestic rather than theoretical.

The novel rejects the image of the impervious doctor. Its narrator is intelligent, observant and competent, and also emotionally guarded, exhausted and sometimes estranged from her own feelings. The detached concern that Lief and Fox described as a professional ideal appears in the book as both a necessary tool and a cost: it allows work with the dying to continue, but it also separates the narrator from those closest to her. Halpern's (2001) critique of detachment is dramatized rather than argued.

The narrator's burdens resemble the three dimensions of burnout identified by Maslach and Jackson: depletion, a distancing from persons, and doubt about efficacy. They also resemble what Rushton et al. call moral distress in palliative care, where clinicians must decide how much to say, when to stop treatment, and how to balance a family's wishes against a patient's comfort. Because the book is set against the pandemic, these strains are amplified by collective exposure. Greenberg et al. note that healthcare workers faced moral injury when circumstances prevented them from giving the care they believed patients deserved; DeForest's "plague years" cohort carries that atmosphere into its formation as doctors.

The pandemic also reveals physician vulnerability in the most literal way: doctors who tend the sick can themselves sicken and die. Butler's (2004) claim that bodily vulnerability is the shared condition of all lives is made concrete here. The doctor is not outside mortality but inside it, and the novel's narrator knows this.

The novel positions its fellows as a generation formed by the pandemic. The twenty-first-century pandemic exposed the fragility of life and the interdependence of health systems and human survival. Physicians continued working despite extreme risk and uncertainty, witnessed suffering and death in hospitals, and faced burnout, anxiety and pressure to make life-and-death decisions; many lost their own lives. DeForest's narrator belongs to a cohort for whom mass death is not history but training. This framing matters for the medical humanities: it shows that how doctors learn to care for the dying is shaped by historical crisis, and it makes plain why the humanistic aspects of medicine, communication, ethics and emotional reflection, are not luxuries. The pandemic, in other words, strengthened the case for the field's founding claim that medicine is a human practice before it is a technical one.

In a palliative setting, the narrator's principal instruments are not drugs and procedures but attention,

communication and presence. The novel's interactions between physicians, patients and families are moments of listening, reassurance and emotional support, and it emphasizes trust and compassion as the basis of the doctor–patient relationship. Healing here is redefined: not the removal of disease but accompaniment through the final stages of life, guiding patients and families toward understanding and dignity.

This redefinition aligns closely with Cassell's (1982) argument that relieving suffering requires attending to the person, with Gawande's (2014) insistence that the goals of medicine include what matters to patients at the end, and with Charon's (2006) account of attentive listening as clinical skill. It can also be read through Tronto's (1993) phases of care: attentiveness to need, acceptance of responsibility, competence in meeting it, and responsiveness to how the cared-for person receives the care. The dying patient is encountered, in Levinas's (1969) sense, as a face that makes an ethical demand that cannot be reduced to a diagnosis.

The presence of a chaplain in the narrator's own household sharpens this theme. Chaplaincy and palliative medicine share a vocation of being with people in extremity. Yet the novel shows that these shared vocations do not automatically produce intimacy at home: the capacity to be present to strangers' grief may coexist with difficulty being present to one's spouse. The book thus complicates any sentimental view of care as unlimited.

The novel does not look away from the physical facts of death. Reviewers mention autopsy and organ harvesting among its subjects (Kirkus Reviews). These scenes engage Foucault's (1973) clinical gaze, in which the dead body became the privileged source of medical knowledge, and Kristeva's (1982) abjection, in which the corpse confronts the living with the boundary of their own existence. In the physician's hands the body is at once an object of study and the remains of a person. DeForest's sardonic humour, which reviewers note, functions as a coping mechanism and as a critical device: it admits the horror and absurdity of the clinical encounter while exposing the defence mechanisms by which clinicians endure it.

The death of the estranged father is the hinge of the novel. A palliative care physician is professionally expert in dying, and the novel tests whether that expertise survives when the dead person is her own father. The result is instructive: professional knowledge does not exempt the physician from bewilderment, ambivalence and delayed grief. Her relationships, with a spouse whose work is also with the dying and with a young niece for whom she is responsible, show care as something that continues, difficult and incomplete, outside the hospital. In Frank's (1995) terms, the narrative resists the restitution plot: there is no recovery arc, only continued living with loss. In Cassell's (1982) terms, the person who suffers includes the physician.

The novel's form is part of its argument. Reviewers describe it as auto fictional, brief, stylized and closer to memoir than conventional plot (Booklist; Kirkus Reviews; Publishers Weekly). Clinical language, with its case presentations and standardized notes, is designed to be efficient and impersonal, and it cannot easily carry grief, awe or moral doubt. DeForest's lyric compression opens a register in which those things can be said. In this respect the book extends the project of Hunter and Charon: it shows that narrative can reach what clinical genres exclude. Its refusal of a tidy plot and its irony resist the consolations of the "illness redemption" story that Frank warns against. Form thus becomes an ethical stance of truthfulness about death.

V. DISCUSSION

DeForest's novel belongs to a tradition of physician-authored writing on mortality, including Nuland's How We Die (1994), Gawande's Being Mortal (2014), Kalanithi's When Breath Becomes Air (2016) and Ofri's What Doctors Feel (2013). Those works are essayistic or memoirist and tend toward lucid explanation, even consolation. DeForest, by contrast, offers a fictionalized, fragmentary and sometimes disquieting interior view in which understanding is partial. Tolstoy's The Death of Ivan Ilyich (1886), with its portrait of a dying man isolated by the evasions of those around him and comforted by the simple presence of a servant, is a remote but instructive ancestor: both works ask what it means to be truthfully accompanied in dying. Didion's The Year of Magical Thinking (2005) offers a parallel for the novel's attention to grief's irrationality. Compared with Kalanithi's account of a physician becoming a patient, DeForest's narrator remains a physician throughout, and the book asks what happens when the expert in dying is bereaved.

First, the novel supports the inclusion of literature in medical training as a means of developing empathy,

reflective capacity and tolerance of uncertainty (Charon; Cole et al.). Reading it could prepare trainees for the emotional realities of end-of-life work that technical curricula underplay. Second, it argues for institutional attention to clinician wellbeing, including debriefing, supervision, ethics consultation and structures for grief, as protective against burnout and moral injury (Shanafelt et al.; Greenberg et al.). Third, it models honest communication with patients and families, with trust and compassion as clinical skills. Fourth, in contexts such as India, where family involvement in decision-making is strong and palliative care is still developing, the novel's attention to families and to the clinician's emotional experience invites locally grounded reflection on how end-of-life care is taught and delivered.

VI. CONCLUSION

Our Long Marvelous Dying reveals the hidden emotional and psychological struggles of physicians who live with suffering and death in daily practice. It presents the hospital as a liminal space in which life and death coexist; it shows doctors not merely as medical professionals but as individuals who endure emotional pain while caring for others; it locates healing in presence, communication and empathy when cure is not possible; and it uses a spare, lyrical and ironic form to say what clinical language cannot. The novel reminds readers that medicine is not only about curing disease but also about understanding suffering, dignity and humanity. In the corridors of the hospital, physicians struggle not only against disease but also against despair, holding the fragile hope of life. By giving that struggle language, literature makes a claim on how medicine should be taught, practiced and sustained.

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