

See One, Do One, Teach One

Category: Stories

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Back when I was in graduate school and working as a medical writer, a physician told me that the key to learning medical knowledge was simple: see one, do one, teach one. It was a clever (and effective) way of convincing me that I was qualified to teach something—like how to write a report—that I'd only attempted once myself.

Now, on days when nothing goes right, I find myself thinking back to that expression—and to the years when I used to see and do more, before I tried to teach anyone anything.

Soon after college, I worked at a private outpatient facility supervising the care and treatment planning for eighteen developmentally disabled adults. I was, in my own fashion, hoping to make a difference.

My program taught skills that would, we thought, enable our students to enter the workplace. But after years of observing and tracking their progress, I came to understand that most would never hold a job—and that some disabilities outweigh even decades of hard work and incremental improvements.

Some of my class, after taking doses of Haldol or Thorazine on a hot afternoon, would glaze over during group activities. I'd keep an eye on them as they napped in the shade (photosensitivity was a problem) at a table covered with crumbled snacks and third-rate coffee in polystyrene cups.

When overworked higher-ups asked me about this "activity," I'd simply say, "Psychotropic medication makes them sleepy," then go on to dispense markers and faded construction paper to my livelier students.

As my director surveyed us, I could almost hear her mental litany: at least the crayons aren't sitting in puddles of coffee; at least they've taken their meds; at least no one is getting sunburned. At least Lisa's here, making sure that no one's wandering away, getting hurt, spilling coffee or worse.

I had my own "at least" list. At least things are better here than in the old days, I'd tell myself. At least nowadays that nice man with the gold tooth mops the cracked linoleum, even if its dirt is permanently ingrained. At least now the nurses are kind to their charges.

As I roamed the day in a sort of fugue, my job functions shielded me from the pain lurking just out of range. But at night, when I tried to fall asleep, I'd see the scars on women who'd been healthy infants until they were dropped out of windows or thrown against cement walls by unstable adults. Their files hinted at hidden events, stories that would never crystallize. The fragmented notes on their state-mandated records swam before my sleepless eyes.

On the days after these wakeful nights, as if to compensate for the invisible nightmares haunting the files, I would see things that weren't there.

Geraldo Rivera would flash, unbidden and Banquo-like, before my mind's eye as I heated canned spaghetti for my charges, some of whom were survivors of the Willowbrook facility for disabled children, the subject of Geraldo's famous expose.

Nearly twenty years before my time, Geraldo had achieved something—caused something to be done—for some of the people I worked with. What was I doing for them? Could a lunch replete with high-fructose corn syrup atone for the failures of an underfunded mental-health system?

Finally, after seeing just a bit too much, I burned out and fled to graduate school. Looking back, I was trying to move into a more hopeful world, away from the grinding hopelessness of permanent disability.

Gradually, over the course of years, the gritty memories of this job faded, and eventually I got involved in medical matters through research and writing. I no longer did anything directly related to caregiving—no longer fed the disabled or made sure the coffee was fresh—but my modest work reached many more people. I studied and wrote, researched and published.

Today as a college professor, I see my students' faces as they learn to interpret disturbing material—like images of the 1918 influenza pandemic.

My healthy, high-achieving students sometimes find even this distant form of bearing witness unsettling. They're unsure of what to do, to say, to think. Some of them wait for me to tell them what they should be seeing, so that they can get started doing something. I try to teach them to look beneath the surface of their world and seek to understand it a little better before they go on to medical school, law school or other pursuits.

I don't blame them for feeling disturbed by the material, because I find some of it as upsetting as they do. The biggest difference for me now, compared with my younger self, is that I've read a lot about how creating narratives like this one can help to ease trauma by reframing it. I'm not sure how it works, but I like to believe that it does.

My workspace these days is a blend of Victorian architecture, valuable art and piles of well-thumbed books. The coffee cups are biodegradable, and the cookies are fresher than they were back when I "habilitated" people. But I still picture my former charges' gently nodding heads as I do my best to teach my current students well. I perceive that I have followed the arc of seeing, doing and teaching. I saw. I did. And now I teach.

And though my students' thoughts and words sometimes move me to tears, my feelings these days are tempered by the maturity I lacked back when I dished up canned pasta and wiped coffee rings off the tables each afternoon.

About the author:

Lisa DeTora PhD is an assistant professor of English at Lafayette College in

Easton, PA, where she teaches Environmental Writing, Medicine and Melodrama in a Global Age and other courses. “I wrote this piece after completing the Advanced Narrative Medicine Workshop at Columbia University’s College of Physicians and Surgeons. Because of the work I’d done there, I found myself thinking back to my own experiences in direct care.”

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