

24/7/365

The International Journal of Healthcare & Humanities



© Lee Miller Archives, England 2010. All rights reserved.

VOLUME FIVE • NUMBER FIVE • SUMMER/FALL 2010

PENN STATE UNIVERSITY COLLEGE OF MEDICINE
DEPARTMENT OF HUMANITIES

The International Journal of **Healthcare & Humanities**

Volume Five • Number 5 • Summer/Fall 2010

Penn State College of Medicine • Department of Humanities

©Penn State University, Department of Humanities ISSN: 1941-5613

The Journal is also published in electronic form by the Penn State University Libraries. <http://publications.libraries.psu.edu/eresources/ijhh>
ISSN: 1941-5621

Editor-in-Chief

Cheryl Dellasega, C.R.N.P., Ph.D.

Professor of Humanities

Penn State College of Medicine/Hershey

Professor of Women's Studies

The Pennsylvania State University

Ronald Domen, M.D.

Poetry Editor

Professor of Pathology, Medicine, and Humanities

Penn State College of Medicine/Hershey

Esther Dell, AMLS, AHIP

Associate Editor

Associate Librarian

Penn State College of Medicine

Daniel George, Ph.D.

Dissertation Abstracts Editor

Department of Humanities

Penn State College of Medicine

Deborah Tomazin

Managing Editor/Graphic Designer

Department of Humanities

Penn State College of Medicine

The IJHH Journal is published biannually and subscription cost is \$15.00.

Orders for new subscriptions or single issues should be sent to:

Penn State College of Medicine

Department of Humanities, H134

500 University Dr., P.O. Box 850

Hershey, PA 17033-0850

On The Cover:

Title: Lee Miller in Hitler's Bathtub

Location: Hitler's Apartment, Munich, Germany

Date: 1945

Photographer: Lee Miller with David E. Scherman

© Lee Miller Archives, England. All rights reserved.

Content

Letter from the Editor	iii
Ground Work	1
Jeanne Bryner, R.N., B.A., C.E.N.	
An Everyday Clinic	2
Aarthi Rao	
Children’s Miracle Network Drawing	7
Ben and Drake Manthely	
Seeing Through the Mask: based on a True Story	8
Clayton Hess	
Pediatric Orientation.....	10
Jeanne Bryner, R.N., B.A., C.E.N.	
Lee Miller Photographs: Friend to Nurses	11
Lee Miller Archives - Cheryl Dellasega, Ph.D.	
On the Loss and Gain of Self: (Pop) Cultural Treatments of Organ Donation.....	15
Rachel A. Wortman, M.A., Ph.D. Candidate	
Children’s Miracle Network Drawing	21
Amanda LaRose	
Wonders and Woes	22
Brittany Irely, MS IV	
Hostility	24
Seth Ilgenfritz	
A Drop of Blood.....	26
Muriel Murch	
Children’s Miracle Network Quilt.....	29
Julia Shaubach	
Abstracts	
Gimeno i. Domenech, Maria Montserrat	30
Sarah A. Vogel.....	31
Daniel Tafner McGarry	32

Editor's Column

Cheryl Dellasega, G.N.P., Ph.D.
Professor of Humanities at Penn State University
College of Medicine, Department of Humanities,
Professor of Women's Studies at Penn State University,
500 University Drive, Hershey PA 17033-0850
cdellasega@psu.edu

Greetings Readers:

Just like the unpredictable weather we've had here in Hershey this summer, the work on IJHH has also been somewhat erratic. For that reason, we may need to rethink the label and call it late summer/early fall. Kudos to both readers and contributors for being so patient in receiving this issue.

Although we didn't not intentionally structure this issue around nurses, many of the pieces submitted ended up with that focus. More creative works around the personal lives of health caregivers are welcome in the future, as are photography and other visual media. The brightly colored pictures you see scattered throughout were generated by young patients from our Children's Hospital, and the photographs were purchased at a generous discount from the Lee Miller Archives after nearly a year of negotiation. You can read more about this fascinating woman on the web at <http://www.leemiller.co.uk/index.aspx> or in the many books her son, Tony Penrose has written about her. As the daughter of a nurse, she carved new inroads for female war correspondents.

We also appreciate the many other faithful contributors and readers who help IJHH continue to deliver an important message to all those involved in healthcare. That means every one of us.

Warmly,
Cheryl Dellasega
Editor-In-Chief

Ground Work

Jeanne Bryner, R.N., B.A., C.E.N.
3209 St, Rte. 534, Newton Falls, Ohio 44444-9709
330-872-7860 jebryner@gmail.com

I was seventeen when God taught me
how to hold on during a seismic disturbance,
how to share the earth with the grisly bear of loss,
so now, at fifty-eight, when the doctor asks,
How bad is your pain? (after he drains my left
knee and injects his milky medicine), I lie
flat on my back, eyes closed, a fern on the forest
floor mashed by some hunter's boot, humus
in my hair. Without thinking, both hands rest
across my chest, folded, secure in my faith
this preacher man can save me from a distant gale.
I want to spring up, sprint back to summer,
but I'm not a palm tree, and his question makes
me wonder if we copy seeds, root in cool dirt
wearing a sky blue suit like Mama did June 7, 1969.
I want to ask my doctor, *Have you ever prayed to die?*
Because even at seventeen with good people gushing
and hovering around, every breath
felt like swallowing a knife.

Author Comment:

*My last book of poetry is about four generations of women in my family. The final section is about me. I have lots of trouble with autoimmune arthritis and had a knee surgery last fall. As a care provider we nurses are always after a *number* for pain. All pain is relative. The loss of a parent is catastrophic/unforgettable, so a knee aspiration was not so bad.*

An Everyday Clinic

Aarathi Rao
 Program Associate
 Results for Development Institute
 4530 Connecticut Ave NW, #303, Washington, DC 20008
 Phone: 202.470.5732
 email: arao@resultsfordevelopment.org

Author Note

This narrative is based on experiences that I had while carrying out field research with the Johns Hopkins University as a public health student. The Second Decade Society supported the work. Currently, I work for the Results for Development Institute, and I have no conflicts of interest.

¹Some of the names in this piece have been adjusted.

An Everyday Clinic

The rain beats down on my umbrella. After two weeks of relentless Nepali monsoons, parts of the umbrella have caved in and torn away from its crooked metal frame. Now it is lopsided, shielding one side of me at best. I wipe the water from my forehead and look to the end of the road. I have almost reached the clinic. I dig my boots into the slippery muck and slug forward up the muddy hill, sliding back by almost as much. I maneuver around a family of ducks who have started to swim in a newly formed puddle. Although the puddle occupies only a few square feet, the pale ducklings stay close to their mother. I look down at my pants. The bottoms are brown with mud.

“It’s hard to keep clean isn’t it?” Shobana, the head nurse, smiles politely and passes me. I roll my eyes without thinking. Shobana succeeds to wear white salwars and open toed sandals everyday throughout monsoon season without appearing one bit unkempt.

I ignore it; all of this is normal for Shobana. Reluctantly, I walk through the clinic’s gate and sit down at a waiting table under a wooden shelter. I attempt to wipe some of the mud from my pants, but I just receive stares from the waiting patients. I am accustomed to this. If it is not the mud then it is my boots or my loose hair. The patients usually edge away suspiciously. It is not until I greet them with my overly rehearsed “Namaste” that they grant me the immediate trust afforded to a Western accent.

“Hello, Aarathi!” Rabindra, the lab technician, sits down at my table. “Don’t worry about the mud. You look nice today.”

Unlikely, I think. “Thanks.”

“There will be a delivery today or tomorrow. A woman has just been admitted to the maternity ward.”

“Wonderful! I’ll stay until she delivers her baby.” Ever since I arrived at the clinic earlier in the summer, the staff has repeatedly told me that deliveries were so common that I would see a dozen by the season’s end. At first I had not been particularly interested in births, but

at the staff's insistence and after reading dozens of articles on Nepal's maternal mortality, I have grown curious. This is supposedly one of the best clinics in the countryside; if there is anywhere to deliver a baby in Nepal, it is here. By some twist of fate though, I never happened to be in the clinic during deliveries. Births somehow cluster around my days off or occur by surprise in the night.

I begin my day as usual, but with an eye on the maternity room. In the morning I help the older nurses, who have become too slow to work with patients, roll cotton balls from large sacks of loose cotton. They sit next to a bulky hanging scale where women come to weigh their infants. If the number seems too low, one of the older nurses pushes her sack of cotton away and fills a brown fibrous jute pouch with thick nutritional flour that the nursing students prepare in the back room. The women are always pleased with this free sack of flour and promise to return. Once one of the nursing students finishes her morning duties, she helps me interview each of the waiting patients. I spend the majority of the day interviewing the patients in the waiting room about the clinic's community-based insurance program. Do they use it? Do they understand it? The answer is usually no; it's the women who bring their children to the clinic, and they are often too illiterate to know what is written on their insurance card or what the program does. More often than not, their husbands register for the program, but they commonly fail to explain its benefits to their wives. The only communication is an instruction, "Show this card at the clinic." The women bring their insurance cards, but they are never certain as to why. We always conclude the interview with a rudimentary explanation of the system and its benefits. When I prepared for this trip in the spring, poring over articles on community-based health financing, I had not considered how the status of women in Nepal would relate to my research. For the most part, I anticipated complaints regarding lack of services, inconvenience, or cost. Yet despite the wait times and the confusion regarding the insurance program, patients value the care provided here; people descend the hills from miles around to visit this clinic. The health system of Nepal is largely decentralized with a series of health centers, health posts and more rural sub health posts. This particular health center, situated in the foothills outside of Kathmandu, is uncharacteristically well staffed and accessible.

On the days when I finish rolling my sack of cotton before anyone is able to translate, I watch the activity from a side bench. Although the clinic is small, it is one of the largest structures in the town. Villagers lounge on the waiting chairs and use it as a meeting place. It is not just a health center, but also a place to share news and gossip. When I first decided to work in the clinic for the summer, I pictured a very different life. I imagined constant activity, but slowly I accepted the relaxed pace. I find a new kind of peace when I watch the clinic's visitors. Their mannerisms and quick conversations interest me for hours. Relenting to the lifestyle made the clinic itself easier to adapt to. I expected the clinic to take a more active role in the patients' lives, but in general the staff maintains complacency. It is an everyday clinic. It avoids controversy. It passes out birth control freely, if the patients want it, or secretly if the husbands object; patients tell white lies, and no one takes notice. I finally realized that the clinic only retains patients if it avoids asking unnecessary questions. Since coming to Nepal, I have accepted this "something is better than nothing" compromise. Although my research is financially supported through a grant program at my University, I almost ceased communicating with anyone from school. I can barely remember the absolutes of academics.

In the late afternoons I watch the nursing students go about their house chores. Their small concrete dormitory stands next to the clinic separated by a small boundary wall. Their uniforms hang over the two balconies, drying in the sun, flagging the building as their

own. Unusually, Rabindra yells something over the boundary wall toward the dorm, and suddenly, the girls drop their laundry into buckets, still wrung wet, and scurry toward the maternity room. The baby must be coming; I quickly follow.

I stand in the center of the delivery room with a much clearer view than I predicted. The room is overflowing with people, but the doctor and the woman seem unbothered. If someone had not mentioned it to me when I had walked in, I would have no idea that this pregnancy is complicated. Although the woman periodically folds forward and heaves, she is mostly silent. She wears a loose cotton sari, bunched up to her knees, twisted and damp with sweat. The doctor pushes her legs further apart and scolds her for resisting. He whispers something to the Shobana.

“He’s worried,” a nursing student says to me.

“Will she be okay?”

“Perhaps. There is some trouble—prolapsed cervix.”

The woman moans quietly and writhes in the bed. One of the nurses wipes the sweat from her brow and strokes her arm. I have always imagined a birth to be louder, more dramatic—particularly one without an epidural. Yet this woman keeps her eyes shut the entire time and hardly registers anyone else’s presence. “She’s not on anything, is she?” I ask.

“Like what? You mean pain medications?” the nursing student asks. She laughs. “Where do you think we are? No one uses such things.”

The labor continues for what seems like hours, and I lean against the closest wall. I am tired from simply watching her give birth. Suddenly, I hear a few heavy breaths from the woman as the doctor reaches inside her, followed by crying. I spring forward into the crowd of onlookers. Shobana already has the baby and takes her to a table in the corner of the room. “Wonderful!” I say, clasping my hands together. I crane my neck to see a glimpse of the baby. “They’re both okay right?” There is silence in the room. “Is she hurt? What’s going on?”

Shobana nods, and the nursing student turns to me. “The baby will be fine.”

“Why is everyone so quiet? Shouldn’t we call in the family or something?”

“Shobana just wants to let the mother rest. The baby, I think--I think it’s a girl.”

“So? Isn’t anyone relieved that the delivery happened safely?”

“This isn’t the first time she’s been pregnant, but last time she lost the baby. Her family thinks she’s unlucky. She was hoping for a boy. Her family will be very upset.” Shobana passes the baby to another nurse and walks to the bed. She puts her arm on the woman’s shoulder and whispers. The woman sinks back into her pillow. For the first time she looks hopeless, the determination disappears from her face.

I stay in the corner of the room as nurses help the woman through her final stages of birth. Once she is asleep, a few of her female relatives trickle into the room. They say a soft prayer over the woman and then the baby before returning to the waiting area. I look at the baby, peacefully sleeping, but force myself out of the room into the neighboring ward before I can react. My gut already feels heavy.

“Where is the father?” I ask Shobana as she hunts for fresh sheets in the maternity ward’s supply closet.

“Oh, I think he left already,” she answers.

“He was waiting outside earlier—I thought he might want to see his daughter.”

“No, no. He was just waiting to collect.”

“Collect?”

“The government pays so many rupees to women who come to clinics for delivery. Otherwise, they may go to untrained people. It’s also supposed to help with the expenses of having a new baby.”

I consider this for a moment. “Do you think he’ll use it for the baby?”

“Maybe, who knows?” She pauses. “Don’t worry about such things.”

I look at the baby; she has woken and her head turns toward the window near her crib. It is early dusk and the sky is turning pink. I watch her from the other side of the window; for some reason I can’t break my gaze. She has milky brown skin and narrow eyes punctuated with kohl. Her mother has smeared thick lines of the black paste, ground from lead sulfide, beneath her eyes to protect her from ill wishes. The kohl gives her a presence through the grimy window, but she is small and almost disappears into the folds of her blanket. The mother catches my eye. She is also awake now and sitting upright in the bed. She says nothing and looks away.

The next morning, I wait for Rabindra at the table. “Hello!” he says, as chipper as usual.

“Hello. How’s the baby?”

“Both mother and daughter are fine. And how are you today?”

“Good. Has the family named her yet?”

“No, I don’t think so. Actually, I think that most of the family has left. They’ll name her later.”

“I can’t believe they’re so disinterested. She’s beautiful.”

“What can you do? They wanted a son. You can’t change what people want.”

“It just seems sad.”

“They’re not bad people. It’s expensive in their village to have a daughter.”

“It doesn’t have to be that way.”

For the first time, Rabindra frowns. “Arre, it’s Nepal. People do the best they can.” He leaves the table. I decide that he is right. It is not my place to judge, but it is impossible to deny my distaste for the girl’s family. But how can I justify worrying about one girl, one baby over the dozens that I encounter daily during my walks through town? By the end of the day mother and daughter will be gone, and she will be indiscernible from every other infant that I see.

The next day I hear crying coming from the nursery. “Was there another delivery over night?” I ask one of the nursing students.

“No, it’s the same girl from before.”

“They haven’t gone home yet?”

“No. I think they’ll let her stay a few more days.”

“Is anything wrong with either of them?”

“The mother’s reluctant to go home. Shobana said she’d let her stay for a while until she’s stronger.”

“Why doesn’t she want to go home?”

“Well,” the student pauses. “Her husband, he thinks it’s her fault that the baby’s a girl. He’s upset.”

“Upset? What does that mean? Will he hurt her?”

The student turns away. “He might, but what can we do?”

The prospect of this settles into my stomach. For the next two days, I carefully avoid the

nursery. I am weighed by guilt that shouldn't belong to me. Somehow, it is harder to accept this knowledge as a known truth. I can't imagine that this life of being unwanted will be ordinary for this baby. What will she think of herself? When I hear the baby cry or see the mother take a stroll around the compound with the baby nestled against her shoulder, I try to ignore them. It's just another baby, one of millions.

On the last day of the week, I notice the woman's husband in the waiting area. I watch him roll a cigarette back and forth between his fingers. The tip of a fresh pack protrudes from his shirt pocket. Although the women of the family wait on the other side of the waiting area, he sits alone, staring into space. The wife emerges from the maternity ward. She bows her head toward her husband and joins the remainder of the family.

My body feels stiff and defiant, but all I can do is pick up my interview notebook and resume my work. From the corner of my eye I can see the baby reaching out past her mother, to no one in particular, her small arms jabbing upward into the empty air. I abandon my notebook and go to the skeletal cradle in the maternity room with its tufts of yellowed stuffing bursting from the vinyl seams.

"Why did it have to be her?" I wonder to myself. I can hear the family leaving, their flip-flops squeak in the puddles that have now dried into mud at the clinic's entrance. All I can think is that she is still unnamed. "Good luck my little girl," I whisper, but I know that the baby is anything but my little girl. She belongs to someone else, a world away. It is too bad that adoring someone from afar doesn't matter; she will never know, nor will it matter. I will later learn that Nepal is better than other places in South Asia---it is not known for its female infanticide nor its honor killings. This little girl will face more subtle challenges--her parents' drive for a son, an early marriage, the inability to read an insurance card---it is yet another compromise, I suppose. She doesn't need me. What she will need is something better, something more---education, a job perhaps, the chance to deliver her own children in different circumstances. More than anything, what she needs is what she deserves, a world that welcomes its daughters.

Authors Comments:

This piece draws from my background in global health. It is a meditation on the status of women in Nepal and how they interact with the health care system. As a public health student, I spent approximately 10 weeks in Nepal in 2007, and the experience has shaped how I view public health and healthcare delivery.

Children's Miracle Network

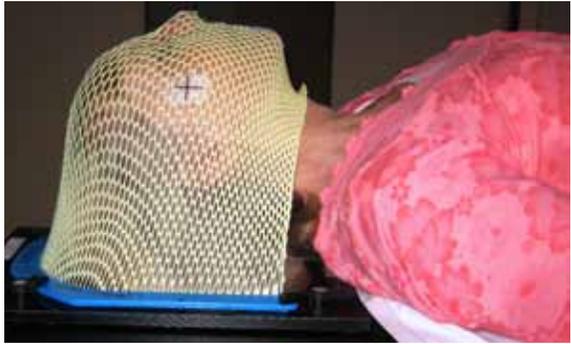
Ben and Drake Manthely
Hershey, PA



Seeing Through the Mask Based on a True Story

Clayton Hess, MS IV
The Pennsylvania State University, Penn State College of
Medicine
chess@hmc.psu.edu

It was not a typical Halloween mask, but the fears it summoned within her far surpassed all the October scares of her life. She would have been very content to never see it again, but had brought it home on the last day of her radiation treatment because she thought her kids might like to see it when they got home from school. Her husband and children had



been like the northern Polaris, constant amidst her spinning surroundings. Her hallowed memories of them as a young family had enticed her to hope when hoping seemed as impossible as seeing starlight through a tempestuous storm. Their penetrating northern shine, seen through the tiniest parting of the nimbus of her cancer, had been enough to re-align her course more than once. Now having just arrived at her empty home, she dropped the sacks she had carried in from the car and there it was, staring at her atop one of the bags. Dark clouds gathered around her again.

Thirty three had been the magic number for her. Thirty three treatments in 6 1/2 weeks. Now it was over. Well, at least the radiation treatment was over. The cancer was not over... not yet anyway. It was too soon to tell.

Just the sight of the mask engulfed her in memory and emotion; it personified the previous month of her life and what the future could hold. It looked like yellowish fishing net that had been pulled tightly over the contours of her face and then somehow frozen or hardened, as if the wind had changed and stuck it that way. Even if the wind hadn't really changed, some things surely had.

She recalled her treatments and the mask seemingly reeling her in from her restful life and bolting her down to the cold, thin table. She wore the mask each day for 12 minutes is all, seven hundred and twenty seconds of panicky claustrophobia. She would look up at the ceiling, at the room, at her world through those fish-net holes as it was lowered down onto her face and pulled so tightly that she couldn't open her eyes at all. That was okay, though—she didn't want to see any more. Seeing only made the whole experience more potent. She didn't want it to be real.

At the end of each treatment session, she heard one of the radiation technicians hurry into the room and quickly reach up and unbolt the mask. Positioned high above the ground on

the raised treatment couch, she could open her eyes again, just in time to see the mask come off. Then he would lower her down and help her out of the room. She was grateful that he hurried into the room. She was grateful that he first removed the mask and then lowered the table down. She was grateful that once the doors opened, she could trust that the mask was coming off, first thing.

When she told her family of her gratitude for the technician's haste, her family commented on her marvelous ability to find the silver lining. "It's just how you choose to look at things;" was her knee-jerk response.

The mask was now staring at her from the bag. She was trembling. Trying to take her own advice, she told her hands to stop shaking and her mind to look at the situation in the best possible light, but they disobeyed. Now that treatments were over, she had to face the next internal storm. Would the cancer return? What would happen to her children? Her shallow breaths tensed up with anxiety and her sobbing eyes turned down in despair. Out of frustrated fear, she grabbed the mask and threw it across the kitchen and onto the counter, watching it collide with all the clutter, including a framed picture of her family during much simpler times. Her own violence startled her.

Many seconds passed, the silence interrupted only by sobs.

Rapid, her breaths eventually slowed. Aching, her gasps slowly subsided. She lifted her eyes to the level of the disjointed counter top across the room and found the mask through the blur of tears. As it came into focus, she noted how transparent it seemed. The thick cords that had pinned her down, now across the room, seemed thin compared to the large spaces in between. She could actually see quite clearly through the mask to the objects beyond it. Pinned against the wall and just behind the mournful mask was the displaced, framed picture of her family.

What she later remembered of the moment was how poignantly a lesson came to her. The faces of her beloved family in the displaced frame were clearly visible from across the room, even through the mask; it was only her perspective that had changed. It would stay changed. Instead of the thick bands that had entrapped her, she now saw the faces of her family. They were smiling through the mask.

Author Comment:

"Radiation Oncology patients undergo intense treatment. They are often immobilized and each day for weeks return to the hospital for treatments that can result in difficult-to-endure side effects. These immobilization devices vary depending on the location of the cancer. Patients receiving treatment to the head and neck are likely to have experiences similar to those in this short story. The juxtaposition presented to these patients as they jump from normal life to cancer life and back again, although a logistically-simple entrance-to-exit footrace each day, can be emotionally taxing. The cancer-center entrance's revolving-door might seem more like a personal and out-of-control merry-go-round. Patients undergo such intense treatment for cancer and their treatment is so involved and prolonged, that the radiation oncology part is often not the worst part of their care. This story was written to spotlight the plight of patients in the basements of cancer centers around the country."

I gleaned how the patient felt about her treatments from a personal email she sent out detailing her trevails, but did extrapolate somewhat in the details of the story. The story, therefore, is based on a true story, but is fictional in parts.

Pediatric Orientation

Jeanne Bryner, R.N., B.A., C.E.N.
3209 St, Rte. 534, Newton Falls, Ohio 44444-9709
330-872-7860 jebryner@gmail.com

I went back tonight
through winter's croupy halls
my first week of midnights, pediatrics.
New grad green
following our charge nurse, Shirley,
her hips wide as a wicker laundry basket,
red lipstick to kiss her Pall Malls at break.
Come to 812 after you check meds, she said
there's something I want you to see.

At 11:00 Cece reported, Acephalus.
Six years old. We have Billy all the time,
another pneumonia. Acephalus: no brain.
A white stem without a flower.
Pneumonia bubbled in Billy's chest
and fever's silent sun singed his limbs.
But nothing I'd learned in Anatomy 210
prepared me for Shirley's black flashlight
held to the child's temple like a gun
her flicking the switch on and off
over and over, over and over.

His crown of chocolate hair lay
in damp ringlets, his cranium blushed
its flaming fluid a full pink moon
without magic, tossed from a planet
of beggars. Shirley's beam gnawed
and nudged, an ant trying to open a peony.
In Billy's lungs, a treadle machine
rattled and hummed, some old woman
sewing a poultice to make him breathe.

His bed exhaled its sweet odor,
diapered loins of the long sick
lukewarm in their kilns.
My two fists choked those crib bars.
How to make popsicles and graham crackers
become the fishes, become the loaves?
In a sacred land, I am a pilgrim,
my divining rod is an IV pole,
it provides drips of well water.
My buckets rust waiting for miracles.

Author Comment:

I can tell you now about the impetus to write "Pediatric Orientation." It seemed to me the nurse was putting on a show of sorts to maybe shock the new nurse (or at least get a rise out of me). The incident saddened me for I felt the child was on display in some disrespectful manner. My youngest brother has cerebral palsy and maybe that's why I felt it was wrong. I mean we'd never do such a thing with family present, so what was the point? All these years later, I ask myself that question.

Lee Miller Friend to Nurses

Lee Miller Archives, Farley Farm House, Muddles Green, Chiddingly, East Sussex, BN8 6HW, England
Tel: ++44(0) 825-872 691
email: archives@leemiller.co.uk

Lee Miller, 1907-1977, grew up in Poughkeepsie, New York. Throughout her lifetime she was a fashion model, photographer, war correspondent, writer, aficionado of classical music, haute cuisine cook, and traveler. In 1944 during World War Two, while working for Vogue magazine, she was assigned to cover a hospital in Omaha Beach, Normandy. It was there that she mingled with nurses and appreciated their role in war, later writing a column published in Vogue titled "Unarmed Warriors." Lee accomplished an unheard of feat of infiltrating the front line of heavy fire at St. Malo, becoming the first female photojournalist during a war. One of her most remarkable pictures (on our cover) was taken in Hitler's abandoned Munich apartment. Lee is sitting in his bathtub with her dirty boots resting on the floor in front of her.



Off-duty nurses resting

Location: 44th Evacuation Hospital, Nr La Cambe, Normandy, France, 1944

Photographer: Lee Miller © Lee Miller Archives, England. All rights reserved



Operating Theatre

Location: 44th Evacuation Hospital, Nr La Cambe, Normandy, France, 1944,

Photographer: Lee Miller

© Lee Miller Archives, England. All rights reserved



Nurse exhausted after long shift

Location: 44th Evacuation Hospital, Nr La Cambe, Normandy, France, 1944,

Photographer: Lee Miller

© Lee Miller Archives, England. All rights reserved



Lee Miller in Hitler's Bathtub

Location: Hitlers Apartment, Munich, Germany, 1945

Photographer: Lee Miller with David Scherman

© Lee Miller Archives, England. All rights reserved

On the Loss and Gain of Self: (Pop) Cultural Treatments of Organ Donation

Rachel A. Wortman, M.A. Ph.D. Candidate
Department of Comparative Studies, The Ohio State
University, 451 Hagerty Hall, 1775 College Road,
Columbus, Ohio 43210
Tel: (614) 292-2559 email: mortman.22@osu.edu

Having finished Catherine Waldby and Robert Mitchell's 2006 book, *Tissue Economies: Blood, Organs and Cell Lines in Late Capitalism*, while being stuck in an airport for 10 hours on my way back from a conference, I boarded the last leg of my flight home hoping for sleep or entertainment. The screaming child behind me ensured that sleep was not going to happen, but the in-flight entertainment proved to be both mind numbing – thankfully – and also provocative. There were two separate TV dramas there spoke in different ways to some of the questions Waldby and Mitchell raise for in their text. On the ABC TV show *Men In Trees* the lonely hairdresser, Terri, has volunteered to give one of his kidneys to the young curmudgeon, Cash. And on ABC's *Eli Stone* a judge was suing the son he abandoned when the child was only two for his bone marrow, as this long abandoned son had proven to be a match - a match that would save his life. The coincidence of this reading and these two programs was certainly interesting, not only because I am often fascinated with how and why popular culture begins to take up questions which are becoming more socially pressing (like this fall's CBS series *Three Rivers*), but also because of the questions of self, rather identity, that these programs raise with regard to tissue donation. Although we are aware that identity is not in-born, that it is not static, and that it is not an object, but rather it is an act of identification, there is some way in which identity is tied to the body or the idea of embodiment. Though Descartes may have us believe that the mind and body are separate or can be separated, he makes no argument as to whether the self lies in either of these two places. Identity seems to straddle these two categories. Thus this paper begins in some way to ask what might it mean to incorporate the tissue of another into one's self, and what that means for one's self? Can we consider it like the process of eating a steak – for that is in fact the tissue of another? As Claude Fischler argues in his 1988 article "Food, Self, and Identity," food is central to our sense of identity as it crosses the boarder between the "outside" and the "inside" and the notion incorporation touches upon the vary nature of person. By extension, then, we should ask: down to which decreasingly cellular part of the body – either in terms of complexity or mass - does one's identity lie or still cohere? This paper takes up these questions at three different sites found in popular culture and Waldby.

Cash, a few days pre-op, walks into the town watering hole for some lunch and runs into Terri. "I am so happy you are here," Terri effuses upon seeing him. "I was hoping we could have a little confab before we go under the knife." Cash appears a bit uneasy at this suggestion and hesitantly replies, "Okay...." "I just feel like if I am going to give a part of myself away I just want to know where it is going, ya know?" Terri continues, "I mean I want to get to know you. We should have coffee and talk." Terri's statements here, 'I want

to get to know you,' 'I want to know where my kidney is going,' are representative of "the complex ideas and feelings about human identity and community" that Waldby and Mitchell speak of, due to "the affective significance of human tissues." Terri is literally, as he points out, giving a part of himself away, but what does that really mean? What does it mean that various tissues are parts of the embodied self, parts which can be disaggregated and passed on to another? Not just digested and passed through another, but installed (if you will) in another person. Is Terri giving Cash tissue or himself? To answer this we must begin to figure out where identity lies.

In their discussion of "Waste and Tissue Economies" Waldby and Mitchell explain, "Generally speaking, human tissues are more likely to be classified as waste as they lose ontological significance. Tissues that we consider essential to the body's integrity and function – organs, blood, skin, the limbs – are strongly invested with ontological significance, and their loss is a catastrophe for the subject." Given the ontological values associated with certain tissues, a hierarchy emerges. This hierarchy is precisely why our authors entitle their book *Tissue Economies* as they remind us: "An economy is also a system for adjudicating value: thus a tissue economy involves hierarchizing the values associated with the tissue productivity." However, in looking at the way in which Waldby and Mitchell frame this tissue economy I would argue that a tissue's value is not wholly related its productivity. Rather, I think that ontology is the better approach. Furthermore, I would argue that a tissue's ontology and thus the emergent hierarchy is not stable. Nevertheless, what becomes apparent, I believe, is some relationship between the sense of identity imbued in a specific tissue and that tissue's significance to the body's overall integrity, function, or a person's sense of being. Or, in other words, the greater a tissue's ontological value the greater the sense of personal identity invested in it.

In the same way that I imagine most of us do not spend much time contemplating our organs, appendages, or skin cells until they are in peril or until there is a chance (voluntary or otherwise) that they might be disaggregated from the whole of our corporeal selves, I am fairly certain that the fictional character Cash did not give a great deal of thought to his kidney until he learned that its failure would mean the end of his life. Furthermore, Terri's newfound focus upon his own kidney, due to its imminent donation, is unsurprising as well. The manner in which Terri goes on about his relationship with his kidney in his conversations with others is quite comical. But between the bursts of laughter the kidney's representation of self and the newly understood link between it and Terri's own identity is revealed.

Oh my kidney and I have had a rich and wonderful life.... Oh my kidney. The places we have been. The streets of Mumbai; that guy in Aspen. My kidney has always had only the best. We saw George Michael before his rest. So where do you think you will take my kidney? It's never been to Dollywood, if you are looking for suggestions.

Terri's desire to share with Cash his kidney's history (really, his own) and his desire to get to know Cash as a person also "speaks" in the words of Waldby and Mitchell, "very directly to the social, philosophical and feminist literatures on embodiment, for [these] understand tissue donation as a way to constitute relationships between embodied citizens, to develop public trust and social equity through systems of exchange of bodily substance." Thus the kidney in their conversations becomes a metonymic object – a part standing for the whole – a part of Terri's body which he himself feels carries his history, and a part of him which will be physically and spiritually transferred or more literally grafted into Cash.

Terri's contribution to the social relationship that Waldby and Mitchell outline is both tangible and clear. However, Terri in turn wants to get to know Cash, for as our authors

have noted these are relationships based upon exchange, and Cash needs to be contributing something to the dynamic. Thus when Cash replies to Terri's suggestion that they go get coffee sometime by disclosing that he does not like coffee, Terri responds with even greater interest. "Well that is good to know. Now we are getting somewhere," Terri declares. It is this 'getting somewhere' which speaks to the level of knowledge Terri needs to have about Cash, or the type relationship of exchange and power dynamic that needs to exist between these two men, such that Terri will feel comfortable enough entering into this tissue economy, entering into this type of relationship.

Cash, on the other hand, has no desire to bond with Terri or to get to know him better. I don't think that I would go so far as to say that Cash's behavior as an organ recipient is atypical – frankly I don't know enough about donor recipient dynamics. But, at least according to the various authors Waldby and Mitchell cite, several studies confirm that the organ recipient experiences this kind of tissue economy as highly personal. Transplant patients feel that 'part of the donor's self or personhood has been transmitted along with the organ.'... [Thus]... it is common for organ recipients to worry about the gender, ethnicity, skin color, personality, and social status of their donors, and be concerned that the organ's 'identity' may over take them.

Given this explanation, Cash's statement in his reconciliation with Terri after their fight about Terri's persistent desire to get to know him better, shows that he does in fact consider this transplant operation to be a highly personal one, one with more than just tissue at stake. Cash explains, "I'm not used to letting people do stuff for me. But I was thinking, having your kidney, maybe you'll rub off on me." Thus within this statement there is an acknowledgement of the manner in which identity is bound up in tissue, as Cash hopes that some part of Terri's self - his traits of generosity and kindness, and his capacity for friendship - extend all the way to his nephrons. Furthermore, the language of Cash's peace offering to Terri at the conclusion of their fight - "If we make it through this thing okay, I was thinking maybe of taking you me and your kidney out somewhere. Maybe a George Michael concert" – makes it clear that he is unable to separate out Terri from his organ. Even in conceiving of their post-operative lives and their post-operative selves Cash sees himself as fragmented in some way – comprised of himself and Terri's kidney. He is no longer just Cash. For the kidney, though physically within him, may never be integrated into Cash's sense of self; it will always be Terri's kidney.

The sense that identity extends to one's organs is not a discussion limited to donors and recipients – and the questions of the ontological value of organs remain bound up in those discussions as well. As of January 2008 issues of selfhood, identity, and organs became a significant part of the debate over potential revisions to the United Kingdom's National Health Service organ donation program, for Britain has one of the lowest organ donation rates in all of Europe. This is a debate that was sparked by comments made by Britain's Prime Minister Gordon Brown on the 14th of January 2008 in a *Telegraph* article about moving to an opt-out rather than an opt-in system of organ donation system. It is a system that would both have save thousands of lives and one that would better reflect the English-common law principle that individuals do not have a property right in their body. In November 2008 The Organ Donation Task Force instituted by Brown rejected the idea of presumed consent; however, despite the task force's findings Brown has not ruled out changing the law. Yet, these are issues with a history, a strain of which is rooted the Alder Hey Children's Hospital case.

The Alder Hey Children's Hospital in Liverpool harvested the organs of deceased children during postmortems – such a practice is consistent with those of many other hospitals (and

is a practice that a move to the opt-out system would echo). However, in 1999, concerned with the lack of formal consent procedures, a community health director intervened and made the hospital's praxis and the existence of the long-standing organ collection public. According to Waldby and Mitchell, who touch upon this case in their book, "Parents who were informed of the practices as part of the inquiry or through media coverage reacted with grief and anger. Some stated that they felt as though the hospital had robbed them of their child, violated their trust, and exploited them at their most vulnerable moments." Looking at the language here – "violated," "exploited," "robbed them of their child". Certainly this language points to the issue of dignity that we can draw upon from Kant. Kant's work, however, dealt with the binary he constructed between dignity and price. And though price did not explicitly enter into the Alder Hey Children's Hospital scandal, certainly the organs were seen as a commodity and dignity was at stake, as "many twentieth-century politicians and bioethicists argued that the human body itself is the locus of absolute dignity, and that dignity involves the preservation and protection of integrity."

But their children were already dead. Their children could no longer speak, or run in the street, or play games; these children were gone. So then how is it – regardless of this question of dignity - that one can feel as though they have been "robbed of their child," due to the collection of his or her organs, unless one has begun to feel that their child's identity extends to the heart, liver, lungs, corneas, or kidney? Furthermore, the parents responses – many demanded repossession of the retained organs, and some went to far as to hold second funerals, "stating that they felt as if their child had died all over again." These responses, I think, do a good job of elucidating the point that I want to make here that identity is, in fact, somehow bound up or existent within tissue.

I do wonder, however, if the parents would have responded in this way, or if the dynamic between Cash and Terri would have evolved in the manner it did if the tissue in question was not organ tissue, but rather blood. For, as Waldby and Mitchell point out, "...whole organs have a greater aura of singularity and sacrifice than blood does, and seem likely to carry a greater ontological charge than a blood donation." So then, if the central questions this paper has taken up is one of identity, then how are we to assess blood?

Going back to Waldby and Mitchell's earlier point—that the tissues we consider essential to the body's integrity and function are strongly invested with ontological significance, and their loss is a catastrophe for the subject—for while blood is certainly necessary for our survival, the level of identity you may see reflected in your own blood is related to just how critical it is to your being. Healthy adults might not feel as though they are giving away a part of themselves each time they go to the doctor to have blood drawn, for a vial or two of blood may not make a difference to their existence. However, a hemophiliac might have a different type of relationship with his blood than this healthy adult. Blood is ontologically significant, but its significance and charge may vary. Furthermore while blood is key to our survival, the manner in which it is processed and stored for transfusion strips a donor's identity from his or her cells.

The changes which have made blood more stable and more usable and have led to blood fractioning—a process by which blood's usefulness can be exponentially increased—has transformed blood from a personal, life giving material to medical matter. Blood has become something more akin to a pharmaceutical than an organ. During WWII, "Giving blood was a way for civilians to participate in the sacrifice made by soldiers at the front, to defend the integrity of the nation by giving part of their bodies." But as we have moved away from the collection and transfusion of whole blood, this one-to-one personal support, the direct relationship between soldier and civilian has fallen away. Today my blood may

carry medical value, but in that it is broken down into fractionates of red cells, white cells, plasma, immunoglobulins, platelets and more, and then combined with the like fractionates of others' donations, my own initial sense of self, extracted from my veins, pooling in a sterile plastic bag, is effaced. Furthermore, for the recipient of a blood transfusion, the highly personal tissue economy felt by those who receive organ donations is nullified as blood's identity has become unidentifiable.

So then are we to say that an individual's identity extends to their organs but not their blood? That this has somehow become a question of scale and not ontology? The issue of cord blood, however, seems to further problematize these questions for us.

Cord blood is unique as it is collected, stored, and revived as whole blood product. On some level we could say that cord blood's ontological charge seems to be similar to that of the whole blood donations and transfusions of WWII due to the fact that the self has not been stripped from the cells, for this is blood that has not been processed or fractionated. However, to say that cord blood's ontological significance is similar to that of whole blood would be grossly underestimating its value, for its value lies in its potential. Cord blood's ontological charge greatly surpasses the scale of its cells or even its volume due to its "striking ability to produce and renew organized tissue." Cord blood holds the dream that its stem cells can be directed to generate (or regenerate) a body's organs; its value lies in these hoped for specific tissues. But people's desire to privately rather than publicly bank their child's cord blood indicates that there is a sense not only of ontological value attached to this blood, but identity, too, as otherwise individuals would be satisfied with the potential held in the public banks. There is something very interesting about the degree to which identity becomes ascribed to this cord blood as the child from which it has been taken has not been in the world long enough to form all that much of an individual identity. These cells which private cord blood banks promote as 'an insurance policy for your child's future that money can't buy' have an ambiguous identity—to whose being does that blood actually belong?

With cord blood banking we are once again dealing with issues surrounding blood donation – the donation of a type of tissue whose usefulness can only be fully realized through processing, unlike the donation of an organ. One's identity might still cohere within cord blood in its whole state, but in the processing of cord blood so that its potential can be realized something interesting happens with this blood and its relationship to its donor. Just like with the processing of whole blood into fractionates, the donor's identity (ambiguous or unrealized as it might be) seems to become filtered out from the cellular particulates of the cord blood. However, in the processing and reengineering of cord blood into organ tissue, or, potentially, the whole organs that science seems to promise us, a new identity gets read onto the cells—that of the scientist. The intellectual identity of the engineer gets imprinted onto whatever tissues he is able to create from the cells of another. The new identity is both affixed legally—through the patenting of cell lines and in bioengineering technologies - and in the realization of cord blood's potential as the engineer has grown a new liver or kidney for someone—just as a live or deceased donor grew, housed, or fostered an organ for a transplant recipient. Identity here is again related to ontological significance—not ontological potential—for it is the scientist who has made it so that this cord blood could be transformed into various types of tissue we consider essential to a body's integrity or function. Thus even if it were my own cord blood that had been used in the manufacturing of replacement heart for my failing one, I could never see that heart as being wholly my own or a fully integrated part of myself due to the intervening processes that would have had to take place to transform that cord blood into a viable organ. It is the scientist in that

instance who would have been saving my life, whose self I would associate with my new heart, not my own. However, I don't know if I would go so far as to say that I would have the same questions or concerns about the identity of my heart, for there is no real donor to interrogate, as presumably this would be an in vitro and not an in vivo heart—a heart that a scientist would have engineered in a lab, and not one grown in his own body. Nevertheless, those would still be my cells. Or maybe they are in fact my mother's cells. It is the point at which medicine, engineering and biotechnology come into play that the question of an organ tissue's identity becomes a challenge to pin down.

So maybe at the end of this we have not quite figured out where exactly a person's identity happens to lie or down to which cellular level within their body it happens to extend. However, what we now have happen to be more questions about cells and identity and what transpires in their exchange from body to body or lab to body. Questions that will help to guide the bioethical side of the seemingly ever-growing tissue and bioengineering economies.

Works Cited

A Tale of Two Kidneys. Men in Trees. Television. Produced by ABC. . 2008.

Fischler, Claude. "Food, Self, and Identity." *Social Sciences Information* 27, no. 2 (1998): 275-292.

Waldby, Catherine, and Robert Mitchell. *Tissue Economies: Blood, Organs, and Cell Lines in Late*

Capitalism. Durham: Duke Universtiy Press, 2007.

Author Comments:

This paper, "On Loss and Gain of Self: (Pop) Cultural Treatments of Organ Donation" juxtaposes Catherine Waldby and Robert Mitchell's 2006 book "Tissue Economies" with treatments of organ donation in popular TV shows to ask what might it mean to incorporate the tissue of another into one's self, and what that means for one's self. This paper posits that there is relationship between the sense of identity imbued in a specific tissue and that tissue's significance to the body's overall integrity, function, or a person's sense of being. Or, in other words, the greater a tissue's ontological value the greater the sense of personal identity invested in it. Ultimately, this paper explores and asks the types of questions that will help to guide some bioethical considerations of seemingly ever-growing tissue and bioengineering economies.

Children's Miracle Network

Amanda LaRose
Mechanicsburg, PA



Wonders and Woes

Brittany Irely, MS IV
Penn State College of Medicine
B.S., University of Michigan
phone: 269-217-7583 email: birey@hmc.psu.edu

It was my first clinical rotation as a third year medical student. I was intimidated and overwhelmed as I focused on staying out of the way of the organized chaos of the cardiothoracic OR suite. The butterflies that were creating their own chaos in my stomach quickly settled as I became mesmerized by what was taking place in front of me. The heart was stopped. A man made pump now had the responsibility of ensuring each vital organ received the normal cardiac allocation of blood and nutrients while also removing the waste produced by our factory of cells. The heartbeat, a physical finding associated with life, searched for with the ultrasound probe gliding over a women's belly and a cold stethoscope placed on the chest of an elderly patient, now before my eyes was replaced with the artificial means of technological advancement. This moment had sucked me in and consumed every ounce of my attention causing me to jump when the resident behind me touched my shoulder and whispered: "Go scrub".

My newfound respect for medical technology was quickly put into question with the horrifying events unfolding later that day.

The room in the corner of the cardiac ICU pulled me towards it, urging me to take a look at the person inside. Those around me spoke with pride about how he had successfully survived the placement of a double chamber artificial heart. However, I was told there was no reason for me to see this patient, as his case was too complicated. That afternoon though, I found myself alongside the brand new intern holding pressure as the patient continued to bleed from every orifice of his body. I was surrounded by alarms ringing, ventilator settings being readjusted, staff working frantically around me as I tried to see the human being lying beneath my hands somewhere amongst the jungle of wires and tubes. I felt a shiver crawl down my spine even though I was sweating and covered in blood, and out of the corner of my eye I saw a family watching all that was unfolding.

Everything was being done to keep him alive. Even though there seemed to me an unspoken understanding of a very grim prognosis. We kept going through the motions, choosing from what appeared to be a bottomless bag of heroic interventions...anything to feel a sense of control, a sense of action. I realized that as long as the technology within his chest kept functioning and the ventilator continued taking breaths for him, he could remain within this room perhaps forever, though his dignity and quality of life had already vanished. Why was so much being done, pain inflicted on both the patient and family, for the possibility of an existence dependent on life-sustaining technology? The person remembered and loved was already lost, now filling the memories of those left behind with the drowning noise of machines. I felt exhausted, empty, and angry as I walked home that night.

I had to ask myself when is enough, enough? When are we causing more harm than good to our patients? When is it necessary to accept that it is time to let go? I could not ignore the vivid

contrast between the events of today and the death of my grandmother. While drifting to sleep that night, the memory of nine years ago replayed itself in my mind as if it was yesterday...

My grandmother was surrounded by her children and grandchildren, the heat of too many bodies, the excited chatter and spirit of the holidays. The room glowed with the warmth of sparkling lights radiating from the Christmas tree and soft carols playing in the background. Gram had triple bypass surgery at the age of eighty-three and never recovered after the surgery, struggling to breathe and consumed by weakness. Her wrinkles, once hardened with suffering, seemed softer now. She lay comfortably in her hospice room with a twinkle of pure satisfaction in her eyes as she watched her beloved family opening presents and trying to sing along with the music, hysterically out of tune. Her energy and wit were astonishing as she actively took part in reminiscing about old times for the rest of the evening. Her internal glow and smile brought a sense of peace to all of us that day.

My grandmother passed away with in her sleep with only her oxygen tank, adequate pain control, and her dignity, a couple days after Christmas. It was hard not to believe that she had held on in order to enjoy this one last moment, now carved in our memories forever.

It is these moments that remind me how sometimes doing nothing, in face of a culture consumed by technology and endless medical intervention, is really doing so much more.

Hostility

Seth Ilgenfritz, MS IV
Arnold P. Gold Foundation Scholar
Penn State College of Medicine
email: ilgenfritzia@gmail.com

I arrived just as my team was dividing the new patients from the previous night. “We got slammed last night. Just look at our list!” my chief resident exclaimed. It was true; our census had nearly doubled overnight. As the interns and my fellow med student divvied up the new arrivals, I was randomly assigned Mr. Smith along with a few other patients. Moving quickly to visit my patients before morning report, I swung by Mr. Smith’s room only to see the x-ray tech walking in. I decided to go to another patient first. After completing that note, I again returned to Mr. Smith, but his nurse was busy in the room now. Giving up, I finished seeing the rest of my patients and came back to Mr. Smith last.

As I gowned up in compliance with the contact isolation sign that hung from his door, I decided to introduce myself with a joke.

“You must be a popular guy,” I quipped. “I had to wait in line out there to see you.”

The room was filled with silence.

Faltering, I went on: “Actually, I had to buy tickets to get in here.”

Nothing. As my eyes adjusted to the dim light I got my first look at Mr. Smith. He was a powerfully built gorilla of a man, and though he was paralyzed from the waist down, he still looked like he could crush me if I got close enough. Realizing too late that this was the wrong room for humor, I quickly tried a new approach.

“Mr. Smith, I’m one of the medical students who will be taking care of you.” He didn’t say a word, but anger seethed from every pore of his body.

I knew from reviewing the medical record that Mr. Smith had been paralyzed for several years, that he had been treated for osteomyelitis from a deep decubitus ulcer on his buttocks, and that he was admitted the night before for acute renal failure. Armed with this information, I started my questions. “How are you feeling this morning?” Mr. Smith glared at me. I tried again. “What brings you into the hospital?” Finally, the frustration was too much for him. He exploded into a tirade of curses against me, against the nurses, against his previous physicians, and against the medical establishment in general. Glad that I was not standing within reach but still not convinced that he wouldn’t be able to lunge across the room and throttle me, I listened uneasily. As I expressed my understanding of his frustration, he grudgingly allowed me to perform a cursory physical exam, and as I left the room he told me in no uncertain terms, that I had 24 hours and after that he was leaving.

As I hurried to morning report, I found myself embarrassed at both my failed attempt at humor, and my inability to connect with this patient. At the same time, I was intrigued by his hostility, which seemed excessive. After morning report, our team reassembled and we began rounds. When we approached Mr. Smith’s room, I presented his case with a warning of his foul mood. I was eager to see how our attending would deal with such a

difficult patient, so I tagged along while the rest of the team waited outside. The attending physician introduced herself and was rewarded not only by silence, but by a complete refusal to acknowledge her presence. She gently asked a question; Mr. Smith stared out the window. She continued to talk, explaining what she wanted to do and why, while he continued to ignore her and glower at his watch.

My attending was struggling to keep the frustration from entering her voice, and Mr. Smith was working hard to maintain his silence, but he was beginning to weaken and I could see it. Finally, the inevitable eruption took place.

“You can’t help me!” he almost screamed, peppering even the smallest phrase generously with expletives. “Look at you! You don’t know anything! You are the reason I’m here and don’t want any of your medicine!”

He continued for several minutes, pausing only for breath. As his anger started to dwindle, however, he eventually began to share why he was so upset at being hospitalized.

It turned out that Mr. Smith had been admitted to the hospital a month ago for treatment of his ulcer with grade IV antibiotics. Since being discharged from his previous visit, he had continued on his IV antibiotics at home with the assistance and monitoring of a visiting nurse. A recent bout of vomiting had dehydrated him to the point where his medicine had reached a potentially dangerous level and he was told to report to the emergency room immediately. The attending assured Mr. Smith that we only wanted to help him and would do so as quickly as possible, and then we left.

I sat down to write his note, perplexed by Mr. Smith’s anger. In his mind he was here because his doctor had messed up on his medication. I could understand that, but his rage seemed to go above and beyond what the situation called for. I screened through previous notes from his primary care doctor to see if there was any clue to better explain his behavior. There was. It turned out that he was paralyzed one night in a freak accident when his roof caved in on him. Here was a physically active man, if his current condition was any gauge, who went to sleep perfectly healthy and woke up unable to walk. That would certainly be enough to put anyone in a bad mood, but there was still something missing.

I continued to care for Mr. Smith for the next several days, treading carefully so as not to anger him. He continued to alienate and aggravate all those involved in his care. He was rude and demanding to the nurses, obnoxious to the techs, and hostile to us.

Finally after two or three days, Mr. Smith declared he was leaving in 10 minutes. This wasn’t entirely unexpected, as he had been threatening this since he got there, but we wanted to make sure that he had everything that he needed before he left. I quickly made my way to his room to assure him that we would be there soon, and over the next few minutes we completed his discharge paperwork and rounded up his prescriptions in record time. In the end it was all in vain, as he was gone by the time I returned to his room.

I stood outside his room at the nurses’ station confused by Mr. Smith’s behavior. Why was he so angry, what made him go out of his way to make others miserable, and why did he stay two days longer than he was planning only to leave 15 minutes before we had his important prescriptions ready? It was then that I overheard one of the nurses talking. Mr. Smith had gone to his sister’s funeral. Finally it all started to make sense. This was a previously healthy man stripped first of his independence, then his sister, and finally even of his ability to mourn properly for her. He responded by trying to maintain what little control he had left in that little hospital room. He was so irate because this medication error had happened at such an inopportune time, costing him precious time with family and friends at a time when he most needed it.

A Drop of Blood

Muriel Murch
Blue Heron Productions
77 Bolinas-Olema Road, Bolinas, CA 94924
email: livinglit@earthlink.net

He notices the blood as he steps out of the shower onto the white marble bathroom floor. Tony Beal and his wife Sarah are in Rome on one of the working trips that now double for them as a vacation. Sarah has long ago given up on real holidays. These working trips come their way frequently as Tony's reputation as a speaker has grown to match his one as a gifted neurosurgeon.

This Rome conference is an international gathering of neurosurgeons. Though most of the surgeons know of each other by reputation, referral and their published monographs these conferences are an opportunity to travel and mingle safely in like-minded company. A neurosurgeon, perhaps more than any other physician, prefers not to be surprised by the people he meets. Few neurosurgeons are women. Women have the dexterity and finesse for the surgery but this brotherhood still doubts their ability to carry the emotional or physical weight needed to pull hard on a cracked skull.

Now that their two children are through college, married and with families of their own Sarah enjoys joining Tony at the conferences. As a younger woman she was withdrawn. While engaging in her children's school activities she managed to overcome some of her shyness but she never became really comfortable at the functions Tony asked her to share with him when they were younger. Now she is lonely at home and, in her heart, admits to pangs of jealousy for Tony's freedom and ability to enjoy himself, with or without her when he is away. But she has grown bolder with age and smiles at herself that now she too enjoys visiting other cities, meeting some of the other wives, who have also been as lonely as she once was. Much of the time she spends discovering her own mind, her own thoughts, ones that she didn't know she possessed. She also sleeps recovering from a deep fatigue, one that unknowing of its source, also surprises her. Living and working beside Tony has been like working a split waitress shift, though without the split break in between.

She begins this trip to Rome by walking aimlessly, until Tony is ready to join her. Later they walk together through parks, wander into museums, attend concerts and browse other cultural interests that Rome offers. Tony's knowledge of history and music make these times more enjoyable. She knows he loves telling her things. Teaching is second nature to him as it is to any man who passionately loves his chosen work.

Tony is an exemplary neurosurgeon. Residents chosen to rotate by his side go on to excel in their own practices. To have scrubbed beside Tony Beal in the big New York teaching hospital would, unless one cracked, set up a young surgeon for a successful practice.

But on this, the second morning of their week long stay in Rome, Tony was not thinking of his successes as he stepped out of the shower onto the warm bathroom floor of their elegant hotel. There was blood on the floor. He was always watchful. Blood on the floor

was something he knew about. On entering a fresh surgical suite his eyes took in the whole room, the gleaming clean steel, the bright lights, the trays of equipment laid out ready for his use, the crisp scrub uniforms of the surgical team, nurses, technicians, the anesthesiologist already attached to and caring for the patient and - the spotlessly clean floor. They all stood in a regimented order for his inspection and approval before he approached the patient. Like an old sea captain he needed to know everything was in its place and as it should be before setting sail into the skull and mind of a fellow human being. When he was satisfied he would then step forward, his registrars and interns following behind him as in a choral wave.

But this morning, when he stepped out of the shower he saw the spot of blood. It was not a big spot. It was not old, dark and dry. As he looked around he saw two new splotches. They were small, seeming to spread like a tiny leaf but one without the vein pattern of the autumnal leaves he knew. Had Sarah nicked her ankle while shaving her legs? Sometimes that happened when she used a fresh razor at home. Had he nicked himself? He leaned forward towards the mirror and absentmindedly reached out for a towel and rubbed his cheeks, though he hadn't shaved yet that morning. The towel in his hand absorbed the water from his face but came away clean.

"Sarah, there's blood on the bathroom floor." He called to her through the half open door to the bedroom. Sarah was sitting on the bed, still wearing the thick hotel robe that she loved to lounge in during these holiday interludes.

"Hum." She replied.

"Have you cut yourself?" Tony asked, neither academically or kindly, not yet on the scent of a trail, but searching, as if for the answer to a crossword puzzle, for the clue to the blood on the floor.

"No, I haven't." Sarah replied absentmindedly. But she too began to think about the blood.

Tony shaved, cleaned his teeth with the disciplined thoroughness he used for all his morning ablutions and looked at himself again in the mirror. He held his head up high, searching for stray soap or whiskers whose remnants would make him seem old and forgetful. He has always held an impatience, a slight sneer for those of his colleagues who didn't keep up their appearances. There was nothing wrong with his face, he thought, it was still handsome. He combed his hair carefully. He still had a good head of hair, a little thin at the back maybe but he could hardly see that from the front and was only reminded of this slight to his vanity as he passed a comb over his head. He gave a little nod to the mirror and himself as he finally shook the towel free of his shoulders, dropping it to the floor before striding into the bedroom. The towel lay crumpled where he left it and the blood, which had softened with the moisture and warmth of his shower, now started to solidify again as the temperature and humidity in the bathroom began to fall.

"Are you finished?" Sarah looked up at her husband and smiled.

"Yes. It's all yours my dear." Tony's tone was affectionate. The memory of the blood receded. He was looking at his wife of thirty-five years. Sexual passion had always ebbed and flowed through their long marriage and now, with rest, the familiarity of desire began to rise in him. Loving trust had overcome the fear that turbulent years of his early successes in their marriage had brought. They recognized each other as the best friend they each had, and like the friends they each made over the years they loved each other despite the faults and frailties they each possessed. They knew each other's moods, knew the signals of desire and need, to be close or to be left alone.

Sarah got up from the bed, went to the bathroom and closed the door. She sat down on the wide marble edge of the bathtub and looked at the floor. She smiled. She wondered what Tony had been talking about. It never occurred to Tony to clean up, to wipe away the blood

from the floor with his used towel. She picked up the used towel he had dropped on the floor. She looked down and then she saw them. Two spots of blood, small, dried and dark. Not much she thought, not really fresh either, but where did they come from? She ran her hands over her calves and looked down at her ankles. There were no nicks or red slashes showing. The angle of the razor had been true. So where had the blood come from?

Sarah picked up the wet towel again. She held it up looking for signs of blood. There were none. She thought about Tony, mentally checking over his body with the mind of a wife and mother who had learnt enough to watch for the physical signs of disease in the bodies of those she loved. Tony's body was good, trim though not tight. A few loose ripples rather than rolls about his midriff. His buttocks were no longer round and firm, though they could and did tighten well, she thought with a smile. His legs, the last to go, as her grandmother had told her, were still slim and fine. They would be considered stringy if his meat was on the butchers block. She shook herself. Where did that housewifery thought come from? Blood she thought, that's where. Her shoulders sank down as her spine curved, lacking the strength to hold her upright for the moment. Where did the blood come from? She knew it was not from her body. There were no tell tale signs of mucus, or bloodstained tissue. She felt no pain. She checked her feet for cracked soles but from just three days of cosseted care her feet were already smoother than they had been for months.

Together Sarah and Tony finished getting dressed and left the hotel to find an espresso coffee bar outside. Tony had the day free and they decided to spend the morning walking in the Villa Bougese and the afternoon further afield wandering through the colosseum. The sun was shining, the temperature was not yet too hot. The air was fresh with the promise of autumn into winter. By the time they met their friends Jane and Peter for dinner they were hungry. The evening was filled with relaxed friendship, good conversation and Italian provincial food. A lovely day ended in an easy evening, they both thought as they walked happily back to the hotel that night.

Their room was fresh and welcoming as a four star hotel should be. The bed was already turned down and the comforter lay inviting them to sex or sleep. The bathroom was clean with fresh towels and soap. Sarah's cosmetics were laid out neatly on a face cloth. Sarah always smiled looking at the way different hotel maids cared for her most personal implements. They prepared for bed and snuggled down into the gentleness of each other's bodies and sleep. The desire that was rising in both of them had been subdued for the night by a good wine with their dinner.

Tony woke early and from a deep sleep and reached for the soft warmth of Sarah's body. He took her differently now. Sometimes on mornings such as these she made her body welcoming, wetting her fingers in her mouth, moving them across her sex, allowing his entry to the moisture that still lay inside her like a hidden cave close to the sea. She welcomed his body and he responded to her welcome like an old warrior. He was grateful for these mornings when she asked for nothing in return. Later they lay together and dozed before Tony rose, satisfied and proud, to shower in the bathroom. Sarah lay in bed, closing her eyes to doze some more. She woke as Tony lent over her, dressed, ready to lecture and face the world of his own creation. He carried the confidence of every man successful at copulation. After the door had closed on him Sarah slowly got up put her feet into the waiting slippers and went to the bathroom. She sat down on the toilet and emptied her bladder before reaching for the robe hanging behind the door. She filled a glass of water and took her morning handful of vitamin pills. Then she sat down on the wide bathtub edge to think about the day ahead of her. What to do? Where to go? As she held the half empty glass of water in her hand she glanced down at the bathroom floor. Yesterday's marks were gone but beside the bath mat, outside of the shower, there was another fresh drop of blood.

Children's Miracle Network Quilt

Julia Shaubach

Age 5

Christiana, Pennsylvania



The effect of music and imagery to induce relaxation and reduce nausea and emesis in cancer patients undergoing chemotherapy treatment

Jimeno i Domenech, Maria Montserrat. Proquest Dissertations And Theses 2008. Section 0173, Part 0519 212 pages; [Ed.D. dissertation].United States -- California: University of the Pacific; 2008.
Publication Number: AAT 3334041.

Abstract (Summary)

The purpose of this study was to investigate the effects of music and imagery versus imagery only interventions on inducing relaxation and reducing nausea and emesis in cancer patients undergoing chemotherapy treatment. Specifically, this study explored an adaptation of the Bonny Method of Guided Imagery and Music (BMGIM). Approximately 280 patients were interviewed, 43 began data collection procedures, and 20 of these individuals completed the study.

Three dependent measures (heart rate, nausea, and emesis) were collected both before and after each of six intervention sessions. Experimental treatment conditions were guided imagery with music (MI) or without music (IO), alternated across the sessions. As part of the experimental treatment, participants were also encouraged to listen to music at home, i.e., to listen twice daily to CD recordings for relaxation. One recording contained a script for relaxation with music in the background, and the other contained only a script for relaxation. Moreover, after the fourth and sixth week of being in the study, the participants responded to a satisfaction survey on their perception on the benefits of MI and IO intervention. A follow-up telephone interview was conducted with each participant nine days after completion of the study. Regression analysis was used to examine factors relating to the frequency of nausea and emesis as well as heart rate. A Pearson correlation coefficient was used to examine the relationship between the extent to which patients utilized the CD for relaxation at home and the amount of improvement experienced. Descriptive analyses were employed to examine participants' responses to their perceptions of the benefits of imagery only and music with imagery interventions (i.e., to the Participant Satisfaction Survey).

Results indicated a statistically significant decrease on post-heart rate for MI as well as for IO interventions. There were no statistically significant differences in heart rate, nausea, or emesis between the two experimental interventions. However, there was a significant decrease in the frequency of nausea and emesis over time, i.e., across the six-weeks of treatment. The Pearson correlation indicated no significant relationship between the times participants listened to the CD and the outcomes of nausea and emesis. Self-reports from the participants indicated that the guided imagery with music, both within the experimental intervention sessions as well as at home, seemed to be very beneficial in inducing relaxation for these particular cancer patients.

Indexing (document details)

School: University of the Pacific
 School Location: United States -- California
 Keyword(s): Music & imagery, Cancer patients, Music therapy, Guided imagery, Chemotherapy, BMGIM, Relaxation, Cancer
 Source: DAI-A 69/10, Apr 2009
 Source type: Dissertation
 Subjects: Music, School counseling, Physiological psychology, Medicine
 ISBN: 9780549869900
 Document URL: <http://proquest.umi.com/pqdweb?did=1646724731&Fmt=6&clientId=17454&RQT=309&VName=PQD>
 ProQuest document: 1646724731

The politics of plastics: The economic, political and scientific history of bisphenol A

Vogel, Sarah A.. Proquest Dissertations And Theses 2008. Section 0054, Part 0337 427 pages; [Ph.D. dissertation].United States -- New York: Columbia University; 2008.
Publication Number: AAT 3333456.

Abstract (Summary)

In the mid 1930s, biochemists first identified the estrogenic properties of several different synthetic chemicals among them bisphenol A. Two decades later this chemical began to be manufactured for plastics production. For the rest of the century, plastics transformed the material environment and economy of the United States, and bisphenol A production skyrocketed. Today annual U.S. production of bisphenol A tops two billion pounds, and this estrogenic chemical has been detected in human blood, urine, placental tissue and breast milk.

Today our bodies are a little bit plastic. How this came to be tells a complex story about the development of ideas about safety, toxicity and risk that informed ideologies of American progress, the relationship between the state and the private sector, and science and democracy over the last fifty years. This dissertation examines the history of the plastics age--when plastics increasingly replaced steel and transformed the material environment, the economy, bodies, and scientific understandings of the implications of this profound change--through the story of bisphenol A from the beginning of its commercial production in the 1950s to contemporary debates over its safety.

The prevailing assumption framing chemical regulation held that the risks of chemical exposure were inevitable and necessary aspects of modern American life, but could be minimized by reducing exposure. Within this framework, bisphenol A was considered safe. In the early 1990s, researchers from several different disciplines articulated a scientific thesis that drew public attention to troubling effects of a number of synthetic chemicals capable of interfering with hormones--endocrine disruption. The endocrine disruptor thesis triggered a politically contentious debate among regulators, industry representatives, and environmental advocates that threatened to dissolve the presumption of chemical safety at low doses of exposure.

Research on bisphenol A was central to this debate. As studies reported disturbing effects of exposure to minute amounts of estrogenic bisphenol A, the plastics and chemical industry struggled to maintain the presumption of its safety. The debate remains unresolved. This dissertation elucidates the larger economic, political and scientific stakes inherent in this struggle to define the implications of the plastics age.

Indexing (document details)

Advisor: Rosner, David

School: Columbia University

School Location: United States -- New York

Keyword(s): Bisphenol A, Chemical policy, Plastics, Chemical industry, Environmental health, Endocrine disruption

Source: DAI-A 69/10, Apr 2009

Source type: Dissertation

Subjects: American history, Public health, Science history, Environmental science

Publication Number: AAT 3333456

ISBN: 9780549858768

Document URL: <http://proquest.umi.com/pqdweb?did=1612599421&Fmt=2&clientId=17454&RQT=309&VName=PQD>

ProQuest document ID: 1612599421

The politics of homelessness in San Francisco, 1988--2002

McGarry, Daniel Tafner. Proquest Dissertations And Theses 2008. Section 0212, Part 0337 354 pages; [Ph.D. dissertation].United States -- California: Stanford University; 2008. Publication Number: AAT 3332882.

Abstract (Summary)

This dissertation explores the political history of local efforts and policies to address homelessness in San Francisco from the late 1980s into the twenty-first century. It traces the origins of a political consensus formed around policies on homelessness that blended local variations of stricture and compassion, wedding welfare reform to a focus on securing affordable housing. It examines how policy initiatives and the high visibility of disorderly activity on the streets of the city made homelessness an issue of unparalleled importance during the period under examination, for the first time, influencing ballot campaigns and mayoral elections. This study connects the events in San Francisco to a broader national story, in which San Francisco's efforts served as examples for policy directions later adopted on a wider scale. This dissertation also explores the bounds of electoral and political possibility for liberal politics in the modern United States, as the most progressive major city in the nation confronted deep-rooted issues of poverty, inequality, and social change. Ultimately, San Francisco's history indicates that policies able to address homelessness can be distinct from those which address more directly the most visible signs of urban disorder, presenting a challenge to San Francisco and other cities that wish to address both of them.

Indexing (document details)

School: Stanford University

School Location: United States -- California

Keyword(s): San Francisco, Agnos, Art, Homeless, Jordan, Frank, Homelessness, California

Source: DAI-A 69/10, Apr 2009

Source type: Dissertation

Subjects: American history, Public policy

Publication Number: AAT 3332882

ISBN: 9780549847861

Document URL: <http://proquest.umi.com/pqdweb?did=1610544541&Fmt=6&clientId=17454&RQT=309&VName=PQD>

ProQuest document 1610544541

24/7/365

International Journal of Healthcare & Humanities

Seeking Submissions

The International Journal of Health Care & Humanities accepts original articles, papers presented at scholarly conferences, essays, poetry, creative writing, and Letters to the Editor. Work that examines the interface of healthcare and the humanities from a global perspective is welcomed.

All submissions will be peer reviewed as per standard practice, i.e. anonymously and with pre-established criteria for fit with the journal. A decision to accept, reject, or request revisions will be determined by reviewers. If you are interested in reviewing for the journal, please submit your c.v. to the Editor. In particular, we seek artists who would be willing to review submissions of photographs and original artwork.

Manuscripts must be prepared in accordance with the style guidelines set forth by the Publication Manual of the American Psychological Association, 5th edition. The Journal reserves the right to edit manuscripts, delete extraneous or excess material, and change titles or headings. Please include a cover letter with your submission that acknowledges your role as creator of the work, along with signatures of any co-authors or co-contributors, and affirm that this is original work with rights owned by the creator(s).

Author Guidelines

Any author involved in healthcare is welcome to submit work. We will accept original research, literature reviews, program evaluations, and relevant creative work such as poetry that relates to humanities and healthcare from a local or global perspective. Papers should be between 1000 and 2000 words in length, typed in Word, in APA (American Psychological Association) format. Send via email to IJHH@hmc.psu.edu. If hard copies are sent directly to the editor they must be accompanied by a CD submission as well. All papers will be peer-reviewed in a timely fashion.

Artist Guidelines

Photographs and original artwork will be considered for publication after peer review by a jury of artists. All artwork including alternative media, paintings, sculpture, prints, drawings, photographs, paper collage, assemblage, installation, digital manipulation, ceramics, and fiber will be considered and should be submitted in a digital format. Please include an artist statement along with your submission. Artists/photographers can send images on a CD or DVD to: Humanities & Healthcare, c/o Cheryl Dellasega, Ph.D., Penn State College of Medicine, Department of Humanities, H134, P.O. Box 850, Hershey, PA 17033-0850 or email digital files (.jpg, .tiff, .eps, .pdf, .psd or Word) to IJHH@hmc.psu.edu.

Please include all contact information with your submissions: name, address, phone, fax, email address, title of work, medium, and artist statement.

To receive a complimentary copy of IJHH, email IJHH@hmc.psu.edu or check the Department of Humanities website at: <http://www.pennstatehershey.org/web/humanities/home/resources/internationaljournal>

24/7/365

International Journal of Healthcare & Humanities

International Journal of Healthcare & Humanities

© Penn State University Department of Humanities ISSN: 1941-5613

The Journal will also be published in electronic form by the Penn State University Libraries.

The address is: <http://publications.libraries.psu.edu/eresources/ijhh> ISSN: 1941-5621