Ars Medica

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Editorial

In his novel *Elizabeth Costello,* J. M. Coetzee asks not only what it means to be human, but what it means to pass one's life as a writer. Elizabeth Costello, at the end of her life, deterred at the gates until she can provide an account of her life's work, a "statement of belief," finds herself unconvincing. She offers first, "It is not my profession to believe, just to write. Not my business. I do imitations, as Aristotle would have said." She flounders with the judges, "I can do an imitation of belief, if you like. Will that suit your purposes?" (194). Her petition for admission is rejected, and she returns to make a more reflective case. After Czeslaw Milosz this time, she states, "I am a writer, and what I write is what I hear. I am a secretary of the invisible, one of many secretaries over the ages. That is my calling: dictation secretary. It is not for me to interrogate, to judge what is given me" (199). Like a bad party joke with never-ending iterations, stranded at the gates of heaven, she is again turned away.

Costello, skeptical and stripped of conviction, is asked the urgent question of meaning and personal belief in the face of the incomprehensible. Like all of us who will eventually encounter the experience of a failing body, of loss, of joy and sorrow in the midst of such humanness, she is left with the task of making sense. Artists may fill a special role in this nexus of experience, for they translate the foreign-ness and exile of illness, giving shape to it through word and image, not just for themselves but for others.

That is what makes the submissions to *Ars Medica* such a privilege to read: being privy to the many attempts to wrestle with such essential questions and to bring voice to experience. These submissions evoke and allow one to witness the enigmatic experience of life within the impermanence of our physical body. They also articulate the notion of what has emerged as a central thread of this issue—the artist as healer.

In this issue of *Ars Medica,* Gertrude Kearns and Anna Hudson find a means to explore the role of artist as one who "makes us whole" and who repairs fractured experience toward coherence. In a section on the Canadian polio experience, historian Christopher J. Rutty provides context for personal reflections by Paul Martin Jr., Paul Martin Sr., and Jimmy Cotter, reminding us that the experience of illness and disease is one that echoes through history, and that our grappling with our individual bodies becomes part of a larger history. Carol Coleman Colapinto's personal journey through the experience of the death of her husband and her children's father affords a moving opportunity to experience *through* and *with*. Steve Dolling also conveys difficult struggles through which he and his family are sustained by humour, and this sustains us.

David S. Goldbloom too shows us that laughter *is* good medicine, and that laughter is one of the fundamental visceral reactions of the body. Powerful short stories by Mary Akers and Jay Baruch pull us into a moment of intensity. Images by Alex Tarnopolsky and Jim Huntley suggest that we contemplate our experiences through many sensory modalities where words cannot necessarily penetrate, and poetry by Jill Leahman, John Grey, Barbara F. Lefcowitz, Susan Cox, Ronnie R. Brown, Alison C. Pryer, Shirley Adelman, and Peter Roberts uses words in unexpected ways, in the service of meaning-making and healing. Essays by Laurie Rosenblatt and Chetana Kulkarni engage our reflective minds.

In a postscript to Coetzee's novel we glimpse a provisional answer to the question of the role of the artist. The artist in "rapture" and in "affliction" and in "extremes" is often the conduit of experience, *witness* to experience. The postscript takes the form of a letter addressed to the cornerstone of rational thought, Sir Francis Bacon, all the more poignant for its impassioned appeal to logic. Lord Chandos writes of his often painful attunement with the experience of all creatures, "Presences of the Infinite": *"[They] press toward me with such fullness, such presence of love, that there is nothing in range of my rapturous eye that does not have life. It is as if everything, everything my confused thinking touches on, means something"* (226).

It is this contact that he attempts to translate with words that are elusive, words that "give way beneath the feet like rotting boards" (228).

We thank all of the contributors to this second issue of *Ars Medica*, and hope that you as reader engage with their movements toward meaning and transformation. We would also benefit from your sharing your own experiences with us. We will strive through *Ars Medica* to continue to provide a place where experiences of the body and of illness can be shared, experiences that might otherwise remain wordless in silence and isolation.

Reference

Coetzee, J. M. *Elizabeth Costello*. London: Vintage, 2004.

Conflict, Conscience, and the Artist-Healer

Anna Hudson and Gertrude Kearns

Artist-healer is a compelling if uncomfortable concept. Is it naïve to endorse the definition of an artist as a seer? Can an artist's revelations be ours too? Art does connect us. We share images within and between cultures and histories. The artist-healer has recently resurfaced as someone who makes us whole.

Fracture aptly describes contemporary life. We are fractured—nationally and internationally—along many socio-political and cultural fault lines. Conversely, we are bound by our shared experience of difference. Is it fair to say the media—newspaper, radio, and television reports of world events—interpret "difference" as "conflict"? We face the challenge of achieving unity in plurality. The division between "us" and "them" means we are forever conflicted by our loyalties. Inevitably one side wins, being one voice or one point of view cut from gender, class, race, religion, or ideology. Being fractured means we are in a state of constant mediation, or conflict negotiation.

***U.S. Console,* John Bentley Mays series**

Aesthetic of conflict is a visualization of the processes of mediation and negotiation practised by the artist-healer. The aestheticization of conflict allows us to experience it from a safe remove. The artwork sits apart from the scorching centre of personal or public conflict in contemporary life. It is a translation of fracture into form: colour, line, pattern, texture,

U.S. Console, John Bentley Mays series (2003). Enamel and oil on nylon, 226 x 156 cm. Courtesy of lehmann + leskiw fine art, Toronto.

rhythm. Thus, the artist mediates conflict. We, in turn, negotiate its form. Elements of the composition function in relation to one another. We exercise our ability to relate parts to the whole and back again. The artist enables us to see ourselves inside conflict.

Gertrude Kearns and an Aesthetic of Conflict

Toronto artist Gertrude Kearns engages an aesthetic of conflict. By this I mean that Kearns visualizes the processes of mediation and negotiation of "self" and of "other" that we experience in contemporary life. These relationships play through various permutations of conflict.

Kearns's aesthetic engagement with conflict relates to a very powerful image of two black orbs caught in an infinite tension. I envision an animated film, an endless loop of drawn frames, each heavily worked in graphite on paper. The orbs race on an invisible track. Without a start or finish, they are forever tied. My image of the slow and deliberate push of one orb ahead of the other, falling back and then surging ahead, exhausts me physically and emotionally. There is never a moment, never a framed still. It is the movement that matters—the progress of tension. Being fractured means we are in a state of constant mediation or conflict negotiation.

***Constricted,* Gulf Conflict Group series**

The 1991 Gulf Crisis had me responding early that year with a series of large black-and-white mixed media works on paper, 1991 Gulf Conflict Group. *The handsaw had become a metaphor for construction and deconstruction in the core group of power play pieces titled* Dialogue, Capability, Mindset, Constricted. *They were about the potency and psychology of military might as I imagined it. I found this reality terrifying yet fascinating. These works had evolved directly from a 1990 series about progress and grief, which initiated my choice of the handsaw as a powerful poetic tool.**

The bombs over Baghdad exploded like fireworks on American television during the Gulf War. It was the first time I experienced a conflict as a spectacle. Such disjunction—my life in Toronto in the same frame as American war in the Middle East—seemed irreconcilable. Kearns

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*Italic indicates Gertrude Kearns's contribution to the discussion.

Constricted, Gulf Conflict Group series (1991). Mixed media on paper, 219 x 146 cm. Collection of the artist.

succeeded in symbolizing this strange juxtaposition in her "saw" works: the *1991 Gulf Conflict Group* series. In *Constricted* the saw is corporeal. It is flesh and steel wed equally for destruction and construction. By intention, our reading of the image is conflicted. Our interpretation is locked in the same dead heat as the orbs.

Kearns's saw shifts and contorts inside the picture frame. The artist provides no clues to its scale. An aesthetic of conflict necessitates our constant mediation within the compositional elements of design: colour, line, pattern, texture, rhythm. We open each like doors in search of the meaning behind them—in search of the bigger picture and rational explanation. In so doing we question our perception, our process of understanding.

Aesthetics is a platform from which subject is further revealed.

Complementaries

Exposed, Serbia #2

I love to use red in the shadows. It gives depth and is hot, and has psychological effect.

Kearns mixes red and green, complementaries (opposites) on the colour wheel, in the body of the young soldier in *Exposed, Serbia #2* (1997). The soldier, shown twice from different angles, reveals two sides of the same predicament. His identity is bred in conflict. The red slashes of shadow seemingly cut angry wounds into his torso. An external calm belies internal turmoil. He simultaneously lives and dies, physically and emotionally, disintegrating and regenerating before our eyes. He is in limbo, suspended by his conflicted state.

Media reports on military conflict try to isolate blame. Despite efforts to separate right from wrong, we cannot escape a nagging insecurity about the line that divides "us" from "them." The line is the interstice or contact zone where opposing forces coexist. Its existence confirms that we can never divide ourselves as a society or as individuals so neatly into good and bad. We all live in conflicted states. This fact is the challenge and opportunity Kearns visualizes as an aesthetic of conflict.

This is actually the same individual, and it is really expressing the active and passive response to being either the victim or perpetrator, so there is a double play there, open for interpretation. I really like to play both sides.

Exposed, Serbia #2 (1997). Acrylic on canvas, 183 x 214 cm. Collection of the artist.

Post-traumatic Stress Disorder: A Private Collapse of Public Power

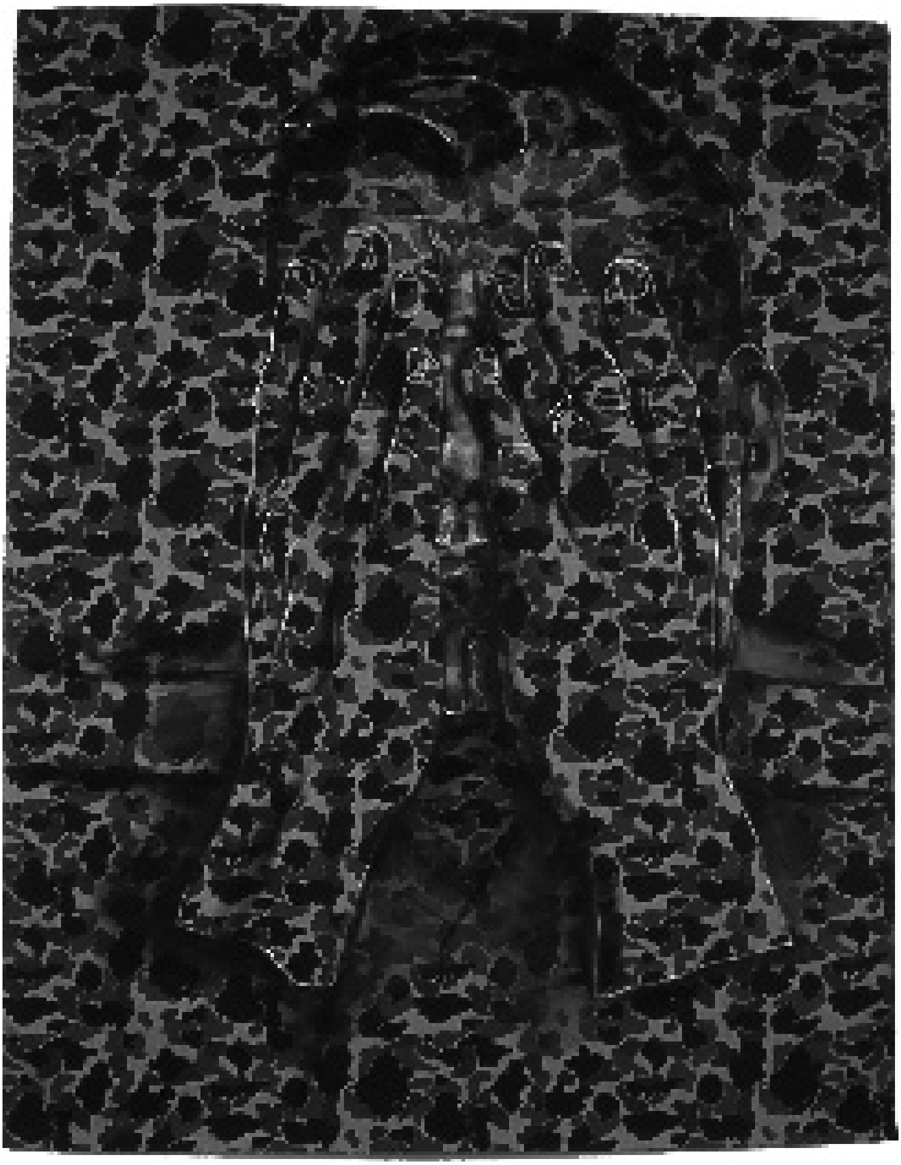
Injured:PTSD

Injured:PTSD *has been acquired by Veterans Affairs Canada. The painting will be exhibited in the Canadian War Museum when it opens in May 2005 in its new Ottawa location.*

Dallaire #6, UNdone series

Dallaire #6 *will be at the Canadian War Museum for an extended period. A photo by* Toronto Star *photographer Rick Madonik was the inspiration for this piece.*

While working on the UNdone camouflage series and researching General Dallaire's situation in genocidal Rwanda, I had the distinct opportunity to



Dallaire #6, UNdone series (2002). Enamel and oil on nylon, 180 x 155 cm. Collection of the Canadian War Museum, Ottawa.

interact with a military member who enhanced my appreciation of the challenges around the experience, definition, and treatment of PTSD. As an individual who had also been in Rwanda, I found that this relationship inspired me, through firsthand reflections, to sidetrack from Dallaire, whose image I had drawn from photographs. Injured:PTSD *is a life study of a man with PTSD. It depicts a soldier without name or rank—one hand relaxed, the other clenching a blue beret in a white-knuckle grip—seated amid four army stretchers: a metaphor for the care required when the injury is psychological and not physical. It speaks to the platform around the issue and the needs and stages of recovery.*

In a less conceptual and more illustrative manner than Dallaire #6, *it is rooted in the same dark debilitating experience and aftermath of mandated inaction in the face of unadulterated mass slaughter.*

Kearns's switch from music to visual art happened over twenty-five years ago when she discovered the rich space between the artist and the model during a life-drawing session. When she began painting portraits during the early 1980s, Kearns sought greater insight into the personality of her subjects. She identified two fundamental realms of experience affecting the character of any individual: external appearance versus internal state of mind. How we navigate the coexistence of these opposing realities defines our nature. Kearns talks often about our existential condition. She pulled faces from the media, shared people in our lives (our collective family) to investigate our common predicament: how do we cope with our circumstances?

General Romeo Dallaire's self-torment in *Dallaire #6* (2001), is the direct result of his inability to cope with his role in the Rwandan genocide of 1994. His impotency in the course of history became his guilt. Kearns studied General Dallaire's despair. She covers his face with his hands.

In *Dallaire #6*, the general is only a man, no longer able to retreat into the emotional compartment of his uniform. His military life has invaded his civilian life and reduced him to a shadow of his former self. Kearns's choice of camouflage fabric as the shifting ground from which Dallaire emerges and is then submerged is a potent refinement of her aesthetic of conflict. We question our perception, our ability to separate the reality from illusion. Two- and three-dimensional space advance and recede like the two orbs locked forever in their attempt to take precedence.

Dallaire's boldly sculpted and camouflaged hands flatten his fleshy face back down into decorative pattern—into nothingness. Dallaire is caught in the very fabric of conflict. He has entered the process of mediation. He is negotiating the web of his conflict.

Depression

A public collapse of personal power.

"I keep thinking about our conversation that a good depression can lead to a lot of great work."

"Yes, especially when it's someone else's."

***Head Study, JBM,* John Bentley Mays series**

The aesthetic comes from a tuned driven mind that strategically reduces for final visual impact. A subject, John Bentley Mays, who also operates within creative formats—writing, in this case—can make for great psychological interplay and fusion, though such an attempt may be presumptuous. The intensity drives the work, and dynamics are expressed in visually aesthetic terms. The use of white canvas in conjunction with the camouflage in Broken *and* Hunter *lends a clinical air to interpretation.*

During the first of four sittings in March 2003 John sits for three hours with his eyes closed. I have put on Australian Lisa Gerard's Mirror Pool, *a contemporary majestic requiem. Her adaptation of Handel's* Largo *is enough to turn your bowels to water it's so moving. After he leaves, the words* Variations on a Himn *[intentional play on hymn] come to mind as a title for the work ahead. It seems an epiphanous moment.*

In his 1995 personal memoir of depression In the Jaws of the Black Dogs *JBM writes of the use and abuse of self in the endless hole of melancholia, buttressed enough with the sonorous weight and "deep harmony of Christendom." I have wondered if there is not an uncompromising discord between his faith and the artist's more existential platform.*

A pivotal period in John's lifetime work and battle with depression is 1968 South Africa. He makes a fascinating and highly disturbing analogy of the posturings and deceptions that made up the reality he experienced to his viewing of himself as an embodiment of that powerfully deceptive regime via his identification with the powerful whites in their organized positioning against the blacks. Through this empowerment he could rationalize his Deep

Head Study, JBM, John Bentley Mays series (2003). Graphite and charcoal on paper, 102 x 64 cm. Courtesy of lehmann + leskiw fine art, Toronto.

Southern American upbringing and keep at bay—at least in a fractured and temporal way—the unavoidable plea for psychiatric help. Here the word temporal *is loaded with pivotal innuendo, as he was there as a representative of the Episcopal Church, which internationally was positioned against apartheid. His body—which he despised as an ineffectual running putrescent orifice, to say the least—was on the most psychologically significant level analogous to the helpless. His body, which he cannot control and despises, is rationalized here as justified situation of the South African blacks, whereas his mind could at least temporarily indulge in this complicity in association with supreme power through this secret identification, granting him respite and the greatest feelings of wholeness and comfort that he had had since early childhood. This is stunning material.*

Today the sixty-five-year-old writer and lecturer holds court daily with his beloved flowering plants under the influence of strong doses of Prozac, still.

The Mays series was a depression spinoff from the 2002 UNdone series about General Romeo Dallaire and his post-traumatic stress disorder, a post-Vietnam terminology: six large head studies on camouflage canvas and three victim murals, the camouflage being a metaphorical ground for the deceptions in and around the UN peacekeeping mission and the resultant confusion and disintegration within Dallaire.

Hunter, **John Bentley Mays series**

Refraction of our sense of ground base via events of terror affects our inner and outer landscapes, resulting in core abstractions of the notion of self and place. With specific reference to Hunter *via the visual inference to 9/11 and the glowing orange demarcations, the fenced parameters are implied as an abstract notion, an abstract cage. With allusion to the* Phantom of the Opera, *the mask is a loaded concept, fragmenting and infiltrating at once, interactive with the will of the subject.*

Elements of Hunter *are precise and representational, with allusion to comic book portrayal through primary abstraction. The graphite circle in the right eye is intentionally pale, as both premise and conclusion to be sought in the scheme of things; the faintness of the delineated pupil, which requires focus by the viewer to hold in his eye, is concurrent with the challenge of the portrait subject to "keep the course," with one eye clear and steady and the*

Hunter, John Bentley Mays series (2004). Enamel and acrylic on nylon and canvas, 181 x 158 cm. Courtesy of lehmann + leskiw fine art, Toronto.

other both part of and knowing "the enemy": at one with the infiltration of the camouflage.

When the outer chaos is internalized and processed though the mental acrobatics of abstraction—calculation, analysis, synthesis—it is the search that is by its nature rational, not the content. This subject is a hunter. His prey is what is both in and around him. He inadvertently hunts his own self.

The act of cutting and shaping the concept of camouflage speaks to creative survival modes in this shifting and dangerous world.

***Broken,* John Bentley Mays series**

You cannot see the person's face at all, only the shape of the skull. Broken *is really a comment on the pains of depression.*

We know it's John Bentley Mays, even without seeing his face. Kearns collaged his distinctive forehead scar onto the camouflage fabric. Collage is a process of building a new whole from fragments. The scar documents a moment of reattachment. It is symbolic of Mays's predicament.

Mays hangs his head and cups his face in two enormous thick hands. They look like gloves, and he looks encased. His white silhouette is a paper-thin veneer over the complex pattern of the fabric. Should we tear away this veneer, we might release the tension Kearns witnessed. In *Broken,* an aesthetic of conflict encapsulates a conflict between mind and body and Mays's desire for being and nothingness. We see Mays caught in an existential cleavage.

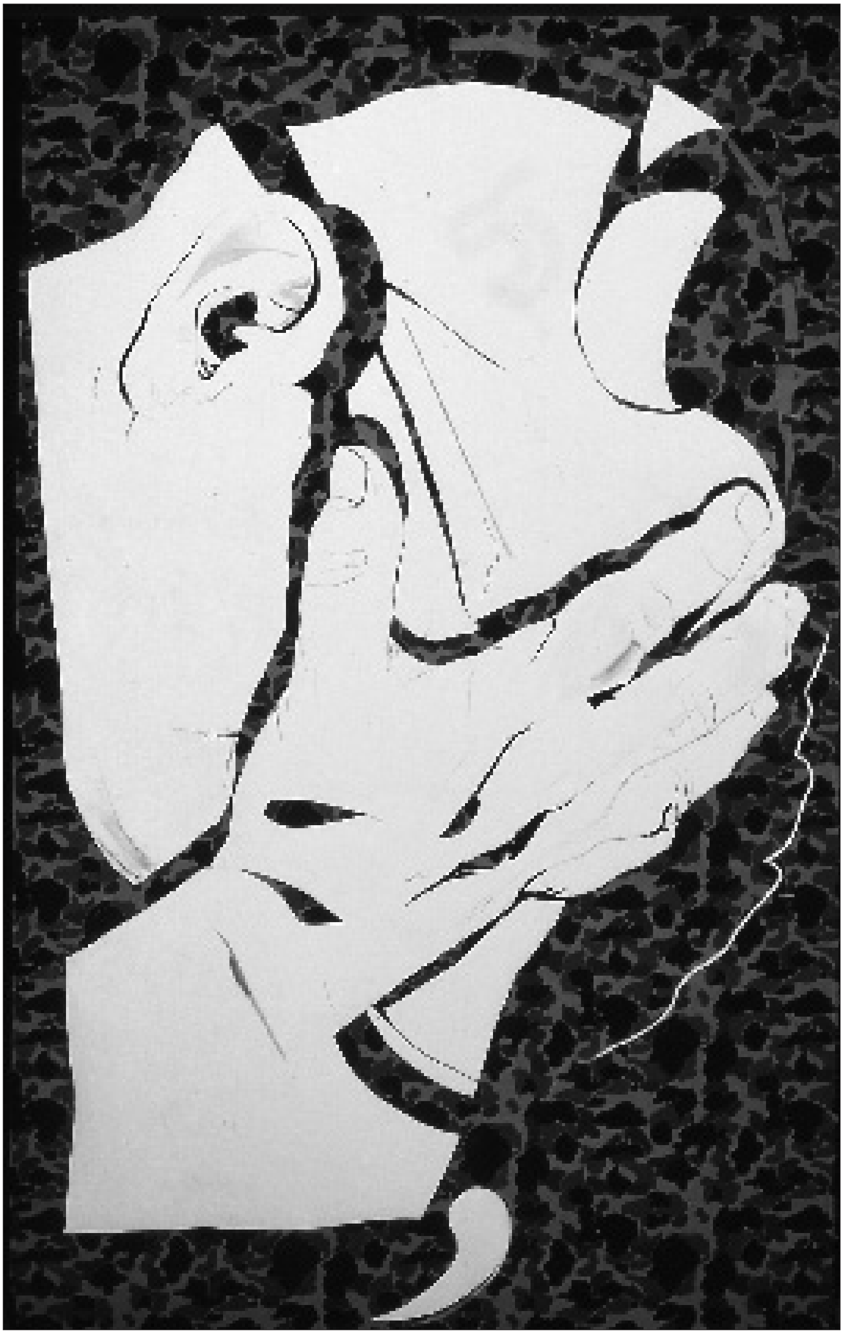
A Pending Piece

(Inspired by The Spiral Stair, *by John Bentley Mays)*

Was it a case of the staircase being spiral?
Or just one stair therein?

How he played with the thing

From perpendicular to spiral
Over and over again
On the unceasing Escher-like machinations
Of his seduction and trap mentality



Broken, John Bentley Mays series (2004). Enamel and acrylic on nylon and canvas, 290 x 156 cm. Courtesy of lehmann + leskiw fine art, Toronto.

When being metaphysical
Must of necessity
Become the sanity in the business of being metaphysical,

The plight of the poet smitten with the delicious allure
Of nothingness, which looms larger than life
And becomes alive, the labelling begins

The aesthetics of nothingness
Strategies in nothingness

Everything in nothingness to everything

An existential opportunity not to be missed

In the climbing up and down of the spiral stair

The perpetual curve of that one step
In all the angles of necessity

Those requisite blasphemies
That must not be forgotten.

The coercions of endless points that do not really meet
For they do not have the nature to do so

For a bibliophile whose penchant both for lyricisms and dissections
Bought him what he bargained for
In the land of ceaseless creations and mutations of such beauty.
He should have been happy, but how could he?
The sap might slow down, but it never stops

In the terror of nothingness

In intellectual positioning not to be reasoned with,
A spirally inclined eye movement

Too rapid, and weighted with that habitual undertow
in the waters of unrequited grief and fear,

For better or worse

The spirally inclined eye movement

That becomes a stare on the wall

A portrait in the hall

From the spiral stair to the hall wall

To hang all he creates

To store all he hates.

Keep the Peace or I'll Kill You

Keep the Peace or I'll Kill You, MacKenzie/Sarajevo

Kearns's painting demonstrates the tragedy of the flesh that *peace* and *kill* can be suspended in such vivid contradiction. It is a reality of Canadian peacekeeping missions shared by MacKenzie and Dallaire.

That's the way life is. The question is how much can we stand to see our predicament in the face of what is obviously horrific.

But how do we face our vulnerability? How do we regain our sense of agency as active players and not passive victims?

We acknowledge the complexity of the world—of life.

Work in 2003 and 2004 evolved mostly around two vastly different public individuals: one literary, the other military; one engaged with his wars within, the other with the wars of the world. One man bisexual, the other heterosexual. One driven to great depths of depression by his inner world, the other who has experienced the true dark side of life in international conflicts yet as a military expert maintains a practical, on-the-edge, upbeat approach to life: Canada's famous soldier General Lewis MacKenzie. The other man is the articulate writer and lecturer, the wickedly dark and lyrically enlightened, complex John Bentley Mays. Both know their respective playing fields, understand deception, can be clinical in approach. Mays is immersed at the psychoanalytical level; MacKenzie has said analyzing can get you nowhere in conflict zones—internal or external.

I wonder how far psychoanalysis has gotten Mays in his conflict zone. Maybe suspending psychoanalysis, "learning the ropes" just outside of it, is a better way of putting it. Both, generally speaking, are greatly admired for their work, yet each has a camp of detractors: people who find them intensely egocentric and even cruel in one case, "a vituperative snake" in the other.

The poster Keep the Peace or I'll Kill You *came after two drawings and*

Keep the Peace or I'll Kill You, MacKenzie/Sarajevo/1992. (2004). Poster of Major-General [ret'd] Lewis MacKenzie. Collection of the Canadian War Museum, Ottawa.

a larger-than-life-size full-figure portrait of MacKenzie, titled MacKenzie/ Sarajevo/1992*—all completed over 2003–2004. In discussion with MacKenzie while assessing the painting he said, "The message is, 'Keep the peace or I'll kill you.'" I responded, "That's it exactly." The poster, which slightly manipulates the large drawing study for the painting, is attempting to more darkly reflect his statement, which he qualifies as reflecting in a basic sense the required post–Cold War approach to realize results in typical UN "peacekeeping" scenarios, where there is no peace to keep, and innocents are being slaughtered. The complexity, highly tuned discipline, and single-mindedness of MacKenzie makes for a powerful force: not everyone's cup of tea in this rather anti-militaristic society—or to use just one of many words MacKenzie might apply with his trademark candour, naïve. The internal conflict and conscience in the face of external conflict shape the psychological armour he must wear to protect his sanity and his capability as a commander.*

The Artist-Healer Is a *Camoufleur*

She may not be what she may seem.

Self-Portrait

This painting is a self-portrait. It is about survival and what it can do to you and for you.

It is about self as congruent projection and deception for the purposes of both physical and psychological survival: action and protection. It is about self-perception in the midst of life and influence and circumstance in this postmodern world of instant accessibility and instant deniability. It is about conscience and cruelty: the self one may need to become.

Is the military garb just incidental? It represents an extreme requirement and change of self in the space between being comfortable, hence protected, and the requirement of needing—or being prepared—to kill in order to survive. What does one lose in the process?

It has been said that you cannot think when you kill. This self-portrait leaves the civilian realm to become an expression of what it means to be a combatant. At the moment of the kill, you are very much thinking.

Depending on what life is offering at the time or on one's abilities to cope, intelligent survival skills proceed from an instinctive mandate to protect oneself.

Mental positioning and acuity are crucial for readiness.

Self-portrait (2005). Enamel and oil on nylon, 230 x 157 cm. Collection of the artist.

Anna Hudson joined the Department of Visual Arts at York University as an assistant professor of Canadian art and curatorial studies in 2004. She was previously the associate curator of Canadian art at the Art Gallery of Ontario.

Gertrude Kearns has exhibited in Toronto since 1983, as a member of Propeller in 2002 and as of 2004 with her representative gallery lehmann + leskiw fine art, where the John Bentley Mays series will be shown this fall.

Mid-winter Night

Jill Leahman

I've invited the cadaver over, asked him
to tuck entrails back into the cavity
because the puppy likes to grab things
and run with them. This would be
a problem, I explain. I tell him
I need a muse and you are as close
as I've come, though by no means
are you traditional. I thought we might
have a glass of wine, listen to Norah Jones,
talk about the state of the garden.
I tell him about my dissertation, how
the due day looms. He just shakes his head,
hollowed cheeks catching the light.

His face dips in and out of shadow.
I tell him about catalogues, pop-up ads, commercials
all hawking an easier, more beautiful life.
He just listens, not saying much. His life is
unremarkable these days. Students work on him,
lifting away layers to study the inner workings
of a body hard-used. He has time to listen.
Outside the front door rhododendron leaves
curl into themselves as if they were trying to find
some warmth on a February night. I take his hand
hardened with chemicals and holding nothing,
thank him for his visit and send him back. He says
the cold is comforting, says he doesn't remember
how a warm body feels anymore.

Summer Party

In the yard people gather in twos and threes,
heads bent, leaning into one another.
Here the scent of rosemary
lingers in the air, released by the weight of feet,
people dancing, arms over heads,
dipping in time, or not in time, to the music.

This is what I miss most, says the cadaver,
the possibility of love. A man and woman sit on the step,
talking, their thighs barely touching. She leans
against his shoulder, laughing and teasing.
The cadaver says the smells will stay with them,
filling a place in memory, so that each time a part of her will remember
these laughing moments. What will remind you of me, he asks.

I have no answer ready. I look up at the sky, clouds
like ghosts. The smell of smoke, pale glow of mushrooms
in the wood, amber of scotch, a cool hand,
closed eyes. I ask if he is leaving and if so when.
He says, the moon has risen full, tells me to watch
for the owl at night. It will guide you
back. Still the dancers dance, swaying in the dark.
all of it too much, the scents of this world, the laughter,
the thighs brushing against each other in the dark.

I finally have his answer.
The moonlight, I tell him. See here, it dances over my arm
and there you are running in my veins.

Jill Karle Leahman lives, teaches writing, and writes in Charlottesville, VA, at the base of the Blue Ridge. Recent publications include *Tough Times, Eclipse, Blueline*. Work is forthcoming in *Poetry Motel, Comstock Review,* and *PMS.*

Wholesale

Mary Akers

There are memories better left fettered in the darkness, untended, unfed, growing long, leggy, and pale, but never finding fruition. They rise unbidden, these images, surfacing in the quiet moments between thoughts, in the darkest hour of the morning, in the stillness of the body, when the mind is wont to wander.

She came into this world impatient to get on with life. Her small dark head of hair emerged restless from the womb, shoulders followed, and she pulled her arms free, pushing herself out as if climbing up out of a pool. No need to slap this baby—her wail surrounded them in the bright white room. Even the mother, through her stupor, heard her child's lungs unfolding for the first time.

Maggie Rand paces the front of the classroom. "Okay, here's your assignment, guys: I want you to give me five pages on forgiveness." The hands shoot up but she ignores them. "Any kind of forgiveness. Use your imagination. A rich guy forgiving a bum for stealing from him, a victim of child abuse forgiving his parents, an ex-prostitute forgiving herself. You decide."

"How about a professor forgiving a student for not getting the assignment done?" asks a voice from across the room.

"Sure," she says. "I'll accept fantasy."

In the bright chaos of daily life, the plain before me lies open, unobstructed. I teach, I modify, I understand. Yet darkness brings a frightful twisted bramble, a thorn-riddled maze with no shortcuts, and wretched rasping demons that lurk behind each dead end.

Soggy oats clumped and swayed in the sloshing bathwater as the child scratched at the blisters covering her body. She scratched until they popped and oozed then sighed as the peaceful delirium of a well-scratched itch spread throughout her body. She had just begun to scratch a fat welt on her cheek when the father came in, clearing his throat loudly. He stared down at the child, sitting in the clotted water, hugging her knees to her chest. "Mags," he said, in a voice heavy with disapproval, "you've got to learn some self-control."

"I'm itchy," she said.

"Your mother and I have told you not to scratch, have we not?"

"It feels good to scratch."

"Scratching will give you an infection. It will make scars. It will make the chicken pox worse. You have to learn not to scratch."

"Daddy, I can't. My body likes it. Scratching makes my itches happy."

The father sighed and sat down beside the tub. "Give me your arm," he said. She glanced up at his face, then extended her forearm over the edge of the tub.

"See this bump?" he asked. When she nodded he took her by the wrist and said, "Watch." With his other hand he scratched in a circle around the blister, staying just outside the reach of angry redness.

"Scratching around the itch satisfies the craving, Mags, but doesn't hurt your body. It gives you time to heal. Got it?"

She nodded.

"But it doesn't feel as good," she said.

Maggie stands in the early morning line, on the seedy side of town, between a suited executive and a rasping, jittery, bag of bones. The line moves and they inch forward looking straight ahead, familiar in their plight, familiar by sight, yet none acknowledging the others.

Maggie has an hour, on Tuesday and Thursday, to get over here and back to campus before the start of her nine o'clock Comp Lit class. On Monday, Wednesday, and Friday she hits the line later since her office hours begin at ten those days. On weekends she doesn't sleep in.

She stares at the familiar grey wall of the building before her, scrawled with a rash of graffiti kings' bright epithets to fame. The next lot contains a ramshackle house of peeling paint and shards of window through which a woman wearing a silver scarf watches the line advance. The smell of urine stings Maggie's nostrils but she can't pinpoint the source. Perhaps it is the man behind her. Perhaps it is the doorway of a nearby apartment building. Perhaps it is the stench of desperation. She feels a tug at her elbow and turns slightly. The man behind her looks imploringly at her face. He must weigh all of seventy-five pounds. When she meets his gaze he smiles, revealing orange teeth with brown crevices between them and streaks of rot inching downward from the gum line. His skin is leathery and creased. The gauntness of his frame and face make it impossible to judge his age.

"Got a smoke?" he asks.

You aren't supposed to panhandle in line and Maggie knows this, but she does have a cigarette. She's planning to quit, it's just impossible right now what with her packed course load, the ridiculous office hours she drew this semester, the unending piles of papers to grade, and coming here every morning for her daily dose of tolerance, her scratch around the itch.

She glances left and right then reaches into her jacket pocket, palms a cigarette, and opens it behind her back. The man extricates the cigarette without touching her hand and says nothing.

I want you to understand the whole tale. Wholesale. My soul sale. Somewhere, within the play of words, I am safe. Therein lies my redemption. The right combination will form a chain and lead me to forgiveness, where absolution waits beyond the door with no knob, no window, and no keyhole.

The father sat back on his distressed leather couch as the liquor rose and swirled like an oil slick in his tumbler. "Mags, I understand from the principal that you are smoking."

"Yeah?" she said, pinching up the fabric of her pants. "All the kids do. So?"

"Your mother found these in your jacket pocket," he said, holding up a thin packet of rolling papers.

"Those aren't mine."

"Mags, are you doing drugs?"

"Those aren't mine. I don't even know what they're for."

"They're for rolling marijuana cigarettes. What are they doing in your jacket?"

"Jeez, Dad, they're not mine. I don't know. Why don't you trust me? You don't ever believe me."

"I will not have a daughter of mine using drugs. You got that?"

"Yeah," she said, looking away. "I got it."

"Jordan, your writing is very good," Maggie tells the student sitting across her desk for the mid-semester conference. "Edgy, but good." He stares at her blandly and smiles without his eyes, which appear to be all ice-blue irises. The pupils sit like tiny pinpricks in the vastness of them, unmistakable eyes of heroin. He's wearing a long-sleeved concert T-shirt advertising a band she doesn't know, with a gruesome picture of blood and gore. Maggie stares at him for a moment, then tilts her head in the direction of a poster she has hung on her office wall with the poem "Invictus" printed on it. She recites the first stanza. "Out of the night that covers me / Black as the Pit from pole to pole / I thank whatever gods may be / For my unconquerable soul." The student looks at her with heavy-lidded eyes. "What do you think Henley is trying to say with those words, Jordan?"

He stares at the writing on the wall and moves his lips while reading silently. "Uh, I dunno," he says with a shrug. "Life is hell?"

She shifts forward in her seat, leaning closer. "I think he's saying that life can be hell. But also that our choices keep us there, or free us from it, according to our actions. Does that make sense to you?"

"Sure, I guess so," he says. "Shit happens."

"But we make the shit, Jordan. We are the instruments of our own destruction; likewise our redemption. Do you get it?"

"I get it," he says, edging away. "I get it."

So. You are to be my confidant? You will absolve me, I suppose. That's fair enough. But give me a moment. A moment yet to breathe as the woman others know. One moment to enjoy the construct of my life before the wrecking ball appears. A moment yet to salvage the few remaining precious bits I cannot bear to lose.

The sixteen-year-old woman-girl hitched the shoulder bag higher and stuck her thumb out into the oncoming traffic. By now she was miles from her parents' prying eyes. Waning sunlight warmed the backs of her bare legs and she squinted against the glinting grills of oncoming cars. Not one slowed down.

Sweat gathered under her breasts, pooling in the centre and soaking the knot of her halter to a limp turquoise. The roots of her hair were damp, and she pushed the #34 ash blond strands of it away from her face, then dug into her bag for a pack of cigarettes. A smoke was what she needed.

Before she could find the pack, a blue Impala with a pimple-faced boy at the wheel slowed down, and she threw her thumb back out. He leaned across the front seat and yelled, "Hey!" The passenger flinched and pushed him back to the driver's side, then stared back at her as they drove away. He held up a homemade Plexiglas bong with one hand and made the two-fingered V of a peace sign with the other. She watched the dust swirl and fade as the Impala peeled off. Shit. She could've used a hit. If only her parents hadn't found her stash and fucking flushed it, she'd have had a fat joint snuggled inside that wad of bills she took.

She switched thumbs and gritted a smile then turned and walked backward, squinting into the sun. She should have brought her sunglasses, but what the hell. You can't be expected to remember everything when you're packing for the rest of your life.

Maggie stares hard at the locked door, trying to fix it into place, but it shudders and clatters before her eyes. So cold. So fucking cold. No one said she'd be so fucking cold. She reaches an arm out from under the blankets to pull them closer and stares at the rash of small bumps that rise like a wave down her arm, lifting the small hairs. Her arm is foreign. It is the fresh plucked skin of cold turkey flesh. It is hideous.

She pulls her arm back under the weight of blankets and stills the image. The arm aches as if beaten with a club. Twenty hours, and all of her aches. She must not let her mind consider how to stem this agony, crossing instead her wrists over her abdomen just before the next wave of gooseflesh turns to nausea and she is retching in the trash can, wishing it were that simple and could be but thrown up, thrown out, thrown away.

Desire lives within me, breathing with my breath, feeding on itself, constant as a pulse, inevitable as heartbeats, insistent as a sore that will not heal. I dream of chasing my protector, begging for his warmth and peace. Then he turns and chases me, wielding peace and warmth to slip to me against my will. I cry out, "Stop!" But always he succeeds. Always, I am the one who finds the vein.

She felt good. The drinks were free. Nobody treated her like a kid. The tokes were free and she was beautiful. Everybody wanted her. Beautiful and burning free. Free as flying. Flying on shiny wings of life as high as life could be. She stared at the liquid man in his radiant coffee-coloured skin.

"It's a cocktail," he said.

"Like a drink?"

"No," he said, flashing an ivory smile. "A speedball."

"A speedball."

She looked into his eyes. The shining jet-black iridescent holes sucked at her until she stumbled and fell. He picked her up. "What does it do?" she asked.

"Do? Baby, it makes you king. It speeds up life. You rule the world."

"Antoine," a far-off voice said, "don't kill her, man, she's a kid."

She grabbed his arm and pulled him to her, hard. "I want to fly," she said, and she could feel it in her eyes.

But when he brought the needle, a black crow beat its wings inside her chest, screeching and clawing to get out, out. He held her wrist and she thought to scream, but as it rose up in her she saw the needle sliding gently under her skin, and a small blister rose up as if to explode. She held her arm out, watching the bubble even as he withdrew the needle tip and pulled her to him, cradling her head in the crook of his arm.

"Shh," he said although she hadn't made a sound. She stared over his elbow at the bubble on her outstretched forearm. It flattened and began to disappear. "Shh, Baby," he said. "Take it in easy, just a skin pop. No vein, Baby, no vein."

The last of the bubble faded to a small white circle, and there was a rising surge in her belly that swelled and spread out warm, buttery, love flowing over her chest, her arms, her legs, into her fingertips and toes, and her scalp glowed and she was held up, cradled, embraced by giant arms that would never let her fall.

"I've tried it on my own. I just can't do it, you know?" Maggie crosses and uncrosses her legs. "I mean, the methadone works, as long as those Gestapo clowns don't try to ease me off like they think I won't notice. Who tells them to do that? I'm on maintenance, right? Maintenance. Status quo and all that. Why do they think they can screw with that?

It's still my body, right?"

"Yes, Maggie, it's still your body. I think you know that," the counsellor says.

"Last time I checked, but I mean who gave them the right?"

"You're upset. I understand," he says behind steepled fingers.

"You understand?" she says, lifting one eyebrow.

"Come now, Maggie, I see more than you know."

"You? See?" she says with a snort.

"You disagree?"

"Yeah, I disagree," she says, jogging her foot up and down. "You see the pitiful human shells that thirst and burn, but that's all you see. You haven't lived it. You haven't felt that surge of lava rolling through your heart, that peace and warmth you never want to quench, that love that slowly dies within you, freezes you out until you add more and more, but still it dims and dulls and leaves you lizard cold." She smiles. "Sorry, Doc. You haven't seen shit."

He sighs. "Maggie, I am not the enemy. I'm trying to help you here."

"So help me," she says, running her fingers through her hair. "Tell the clowns to quit messing with my dosage."

He looks at her for a long moment. "I authorized that," he says. "Your urine came back dirty."

"Yeah? And Carlos told me his came back pregnant."

"I'm not at liberty to discuss other patients."

"Look, I know you think he switched urine on you. God knows how, when your fetishistic goons stand over us and watch us eke it out."

"Maggie, you know full well that without systems in place—"

"Fuck your systems. What about our dignity?"

"Look, Maggie. If you care to—"

"Oh, I care. And for the record, my urine wasn't dirty until you docked my dosage. I need the methadone. The full amount."

"Our therapy is designed to be temporary. You know that."

"I know this: I used for ten years, Doc. Ten years. And six months doesn't make a dent in that. And your fucking syrupy orange handcuffs drive my life. You think I like coming down here every day to stand in line and relive how I screwed up over and over again? You think I like pissing in a cup while some clown with a tenth grade education breathes down my neck? You think I like that? You ever try it?"

"Look, Maggie, you need—"

"I need methadone. As nasty as the shit is, it lets me live my life. I've tried coming off it on my own. I can't," she says, taking a deep breath. "I can't."

"Listen Maggie, the only thing you can't do is throw away the crutch before you've learned to walk. I want to see you get your life back as much as you do, but first you've got to get over this anger of yours. I think we need to look into some relaxation therapy for you."

"Relaxation?" she says, raising her eyebrows. "Relaxation? Tell you what, Doc. You try sitting on a keg of dynamite holding a blowtorch—we'll see how relaxed you feel."

I drift through a graveyard of abandoned emotions, visiting by turns the stone markers—monuments to the depths a soul can slide. To my left lies the wily Wantonness of youth, the greatest loss, the first to go. To the right, the fitful resting place of Shame, banished years earlier, yet slow to die. Another plot enfolds the twins, inseparable in death as in life: Craving and Cowardice here lie entwined, rejoined in the slow rot of ruin. And last, beneath this crimson mound, a defiant Anger dwells. Killed with my bare hands, it has risen, tormented from the grave, stronger in its afterlife.

She applied the makeup carefully, each stroke a meditation, a prayer. The ashen geisha face peered pleading from the mirror, lips drawn beyond their boundaries in brown pencil, gaps filled by a slick of purple to trick the eye. She opted for Cleopatra eyes, dark with charcoal, rimmed in soot. It struck her, as she studied her reflection, that the effect was of violent aftermath: a sickly pallor underlying swollen purple lips and slightly sunken eyes already beginning to bruise.

She held the smooth cool cylinder up to the light and tested the plunger, then looked past it and spoke to her reflection.

"One more time," she said as a silver bead rose from the tip of the needle and slid slowly down its length.

"Just one more."

"Jordan, will you stay after for a moment?" Maggie asks as the students file past at the end of Creative Writing.

"Yeah?" he says. "What?" His eyes fix on a spot above her head. They are tiny pinpricks. “Pinned,” she used to say. She stares at this kid with a mixture of sympathy and collusion. Another initiate into the club. She thinks of the ’80s roach motel slogan: They check in, but they don’t check out.

“I may be overstepping my bounds here, Jordan, but I—”

“Then don’t.”

“I think you might need some help.”

“I don’t.”

“Jordan,” she says moving closer, “are you on heroin?”

“No,” he says, stepping back. “Jesus. You’re not my mom.”

“Maybe not, Jordan, but you’ve got to know. Someone’s got to tell you,” she says, taking another step towards him. “I’ve got to tell you.”

He stares at her, blinking rapidly and breathing in short little gasps. “No you don’t,” he says. “Really. I’m good. I swear.”

“Jordan,” she says, putting a hand on his arm. “Heroin feels like your friend at first. It feels like love. But in the end you just get left holding the bag. You chase that first time over and over again, trying to recreate it, but you can’t, Jordan. You never find that first love again. It’s a hideous lie. It’s not your friend.”

“Um, yeah,” he says, stepping back and shrugging off her hand, “sure.” He picks at a blemish on his chin and looks around her office. “Uh, no offence or anything, but what the hell would you know about it?”

Triggers, they say. Beware them. Like Pavlov’s dogs, I drool for wads of money, for loneliness, for knowing it is there. If it feels good, do it—the careless creed that took my quiet time my dignity my childhood my friends and nearly me.

Mary Akers’s work has appeared in *Literary Mama, Ink Pot, RE:AL, Pindeldyboz, Westview,* and *Wisconsin Review.* She is the recipient of a 2004 Bread Loaf waitership, and will be a returning work-study scholar in 2005.

At Thirteen, Asthmatic

John Grey

Our house succumbs to black.
I try to catch the eye of sidewalks,
but the colours, the cloth, the flesh tones,
hurt more than they dazzle.

Our house goes down with
the church spire and the hardware store.
It is lost to night life
like a drowning man a mile from shore.

Some laughter busts through but cuts the ears.
Even a soft kiss can travel this far,
but by the time it gets here,
is dead from the journey.

Our house shrinks to fit inside
my pajama pocket as I struggle upstairs
to my bedroom, wheezing and
grabbing at my chest.

There's a lover out there
who's waiting for me.
For now, she's not winnable.
For now, she is oxygen.

Medicine Pudding

Lumpy, curdled,
you sit on my plate like a swamp.
You're the colour of bile.
One bite and you twist my mouth
in your vise, suck my tongue
like a toothless street woman.

But the doctor says you are perfection,
you know exactly what is bad and kill it.
Why pretend to be food is your motto.
No sweet, no rich, no creamy,
but whom would I rather have when
the enemy attacks—poets or soldiers?

I feel worse, of course, try as you might
to convince me your vile taste
will be my succulent salvation in time.
Cure more wretched than disease.
You enjoy being a metaphor too much,
that's your problem.

First Day Home from the Hospital

I was the first one out on the street
after the rain.
I felt like the air, cool and clean.
Every shop window I passed
was dark and chintzy
compared to my clarity

and feeling of great worth.
I could feel my thoughts
cleansing my body.
I wanted to tell people
my face was the truth,
only there was nobody else
out and about.
The rain stopped, and here I was.
I had timed it just right,
and no one else
had been so fortunate.
The sun poked through the clouds,
like a god I didn't even have
to ask for.
The breeze did its quick
diagnostic flutter
and blew on,
convinced I didn't have
an unhealthy bone in my body.
It could have been Paris or Venice
or the North Pole,
but it was my neighbourhood,
and despite all of the choices
the moment could have made,
it picked me
and glowed with the wisdom
of its selection.

John Grey, an Australian-born poet, playwright, and musician, U.S. resident since the late 1970s, was recently published in *Inscape, Halifax Review,* and *South Carolina Review.* His latest book is *What Else Is There?* (Main Street Rag).

A Dark Night on 3B

Steve Dolling

Since the time of Spencer's diagnosis there hasn't been any really bad news. From the outset, you expect a journey with ups and downs—progress and setbacks along the way. But really, it's all been good, so far. Up till now.

Sure, there has been a scare or two. There was the bone scan that Tracey saw that had her pretty much convinced that the cancer was spreading rapidly. She took the kids for passport photos, hoping we would have a chance to squeeze in Disneyland. As it turned out, the contrast was just set a little differently in the machine. The doctors were pleased with the scan, as they pointed out to us a few days later.

There was round three of chemo—the nasty event that came to be known as "The Vomit Festival." Truly unpleasant, but nasty as it was, we knew it was just part of the treatment. The 15 per cent of his body weight that he lost came back again in just a few short weeks.

There was that one summary I did in which I actually itemized all the tests, pokes, and treatments that Spencer had undergone in a month. It was truly alarming. The numbers have since doubled or tripled or gone up ten times, but they are all just steps on the path.

Last night was different. I should have known it was coming, but somehow we've avoided it all this time.

The signs were there earlier in the day. Spencer's roommate, an eleven-year-old boy, was having a difficult afternoon. He just wanted to stop his chemotherapy and go home. I don't blame him. At some point you just get fed up. You can bet his mom was having an equally tough day.

Elsewhere in the ward, things were much worse. Tracey relayed a story that they asked for the hallways to be cleared for a "private transfer." A brave kid didn't make it all the way to a cure.

All the signs were bad.

It happened at 12:20 a.m. I know the time to be accurate. My watch is synchronized with both my GPS and that time signal they have on CBC radio. It wasn't Spencer's nurse who came. They sent the most experienced nurse—the leader on the ward—the one who has dealt with all the toughest situations with grace and dignity. This was to be one of her rougher assignments.

She woke me with a smile. The smile was meaningless. That is not to say it wasn't a genuine smile or had a ring of insincerity. No. The smile is just part of a professional uniform. It reflects something deep in the character of an oncology nurse that allows her to help people through the most difficult time in their lives. It is genuine. It is sincere. But you know that with the smile and professionalism can come words that unglue your very soul.

Oncology parents are different breed as well. They, too, are professionals. They deal with the meanest, roughest stuff that life can possibly throw at them and do it with grace and style. They check their kids into hospitals with life-threatening infections, and their major concern is that they might be too late to fill out the menu for the next day's meal choices. I am one of those oncology parents. I can be wakened from a deep sleep, see the smile, and be mentally prepared in an instant for what follows. My reaction will not be shock or horror. The words can slip through my mind and then rip through my gut, but I won't come unglued—at least visibly.

And then the words came. There was something a little bit strange about the delivery. It came with a bit of a giggle, almost, but not quite, a violation of that professional code that exists between parents and oncology nurses.

"Your snoring . . . it's so loud that she can't sleep," she says nodding to the mother on the other side of the room. "Do you think you could sleep in the playroom? We'll come and get you if Spencer wakes up."

Clinical Trials

Today as we enjoyed what seemed like the umpteenth day of hospitalization, we were advised that Spencer would need a nasal gastric tube tomorrow if he wasn't able to eat and drink in reasonable quantities, to arrest the weight loss that started with his last round of chemo. But they were very fair about it. He was offered a little bit of nabilone to stimulate his appetite.

He took it about a half hour before Uncle Johnny left. We had good fun playing in the hallway with the small solar-powered car kit that Spencer hotwired with batteries so he could run it indoors.

All was going well until the nabilone kicked in. Spencer developed a profound interest in a wheelchair in the hallway. He sat in the chair and worked the brake levers back and forth. Back and forth. Back and forth. He was driving a tank. We said goodbye to Uncle Johnny as Spencer sat in his tank.

The imaginary tank was quite captivating for a time, but eventually he craved the motion. "You push my IV pole, Dad. I'm going to drive this thing." In the course of his struggles, he managed to run over one of his IV lines. Three others got tangled in his wheels. I had to put a stop to the whole exercise.

We went back to the room and decided to watch a DVD. His selection was *Looney Tunes: Stranger than Fiction*. Usually he's quite sophisticated in his tastes, but he began giggling uncontrollably, watching Daffy Duck and the Tasmanian Devil. The munchies kicked in, and he desperately wanted me to get him something to eat, but he couldn't actually tell me what he wanted because he was giggling so hard. In the end, he sent me for cookies.

As a parent, I should find such behaviour mildly disturbing, but I found it all rather funny. It would be enough to make me question whether or not I was a good parent, except last weekend I did things on behalf of my child that assure that I am a good dad.

Last time I mentioned nabilone, a kind soul managed to source for us a large box of what can best be described as nabilone cookies. They were represented as a better alternative to the capsules, because they are more effective at stimulating appetite and reducing nausea while making it easier to regulate dosage.

I am not sure which pharmacy dispensed them, but the instruction label was lost in shipment. About a half cookie was purported to be the right dose for a seventy-year-old woman roughly twice Spencer's size. I took them home and put them in the freezer as instructed.

I gave them no further thought until Friday night. I put Foster to bed and was quietly watching TV when my thoughts turned to Spencer. There he was, lying in a hospital, hardly eating much of anything and wasting away. And sitting in my freezer was something that might be able to help him.

But I had a major problem. Without the instructions from the pharmacy, how would I know what dose to give him? I could not subject my child to this kind of risk.

I did what any good parent would: I undertook a phase one clinical trial right in the comfort of my own living room. First, I started with the study design. Normally in a phase one trial, we want to slowly increase the dose and observe toxicity. Now it wasn't as if we had a clinic full of test subjects. After all, there was only me. Well, and Scupper of course.

But if I killed the dog, they would kill me, so I had to limit eligibility for the trial to a single subject. So I figured it this way: I'm maybe three times Spencer's size. If somebody twice Spencer's size took a half cookie, then the correct dose ought to be about three-quarters of a cookie for me, which would scale down to a quarter of a cookie for Spencer.

In the interest of accelerating the trial and maximizing the benefit, I set my dose at two cookies.

The clinical summary? Oh wow, man. To say I've never experienced anything quite like it would of course be a lie.

I've never experienced anything quite like it. At first I was quite functional. I did a bit of email. It started to seem a little strange after awhile. I decided to call my sister to work out a problem with logistics for taking dog and Foster on the ferry to visit Auntie V. She reduced an intractable challenge to a simple solution in no time. Pure magic. I decided to watch a little TV. I have no idea what I watched or how long I watched it, but it was really good.

After ten minutes or two hours, I'm not entirely sure, I started to get very, very hungry. Tracey was probably wondering what happened to all those cookies she baked. They're gone. All I can say is thank goodness I didn't get my cookies confused or there would have been a nasty spiral that would have eliminated the entire contents of the refrigerator.

Eventually, I got very, very tired and went to bed. When I woke up in the morning, I would like to say that I was alert and refreshed. This would be another lie. There appears to be a big a difference between inhaling and ingesting. This is, of course, based on what they tell me; I don't have any first-hand experience. When you ingest, it seems to stick with you for a long time. I did manage to get the coffee made eventually. Breakfast was superb. I had several bowls of Cinnamon Toast Crunch with Foster.

Obviously, the clinical trial was an outright failure. In my ambition to achieve quick results, I ramped through dose escalation much too quickly and executed with a poorly designed protocol. Now I'm going to have to start the whole trial all over again.

We do what we have to do for the well-being of our children. If it turns out that there are no cookies left for Spencer, so be it. I can't expose him to unnecessary risk.

Informed Consent

By now you are used to the style. A deep sense of drama sucks you along for a page and a bit, followed by a quirky twist that tickles the funny bone. This isn't one of those, and if that is what you are hoping for, you are likely to be disappointed. Of course there is no way you are going to believe me here at the beginning. You've been fooled before. Fair warning. I had to advise you of the risk before we begin.

Informed consent. It's the foundation of all the non-emergency treatment and diagnostic procedures at the hospital. Whether it was created as the outcome of enlightened medical care philosophy or was thrust into the health-care realm by an overly zealous legal system doesn't really matter. Inherently, you have the right to choose. Nobody can do anything to your child without your OK. The decisions belong to you.

So how does it all start for the typical cancer family? Some hideous sequence of events brings you to the children's hospital. The first things they need to do are tests. Lots and lots of tests. "Yes, we would like to do an ultrasound, X-ray, CT scan, bone scan, more blood tests, and an MIBG to accurately diagnose and stage your child's disease." Yes, you get to choose whether or not to subject your child.

Inevitably follows some definitive diagnosis and a treatment protocol. The reams of chemotherapeutic agents all have side effects. "This one causes baldness, that one causes high-frequency hearing loss, this one can affect the kidneys, that one can affect the heart, nausea is a common side effect." You listen with bewilderment and some amusement. You have a choice but don't even bother to ask about the alternative. You already knew the first time you heard them say the word *cancer*.

Depending on what you're up against, surgery might be part of the game. A general anesthesia alone sounds like a bad risk. Once the surgeons fully detail all the potential complications when your kid's particular tumour is removed, you sometimes wonder about the benefit of being informed. It doesn't leave you with a sense of comfort, but at least you have the choice.

Then there is the bone marrow or stem cell transplant. Now *that* meeting is a happy one. Let's contemplate the potential major organ failures: kidney, liver, lungs, bone marrow, and very occasionally, the heart. "Oh, and of course there is some risk to the brain, but generally not unless the other organs go first. Oh yes, and of course there is infection. Your options are bacterial, fungal, and viral. They are all potentially lethal, but we do our best." Strangely enough, they don't even mention hair loss as an adverse side effect on this one. Remind me again of the options please, I have a choice to make.

These are all the impossible choices. Not that it is impossible to choose one way or the other. It just feels impossible to believe you are in the situation to begin with. Impossible to believe that you might eventually reach a point where you might want to consider option B.

But it's not all high drama. Every day there are a bunch of informed medical decisions to be made. Would he like this medicine in liquid form or can he take a pill? Gravol now, or should we wait and try to space it between the ondansetron doses? Platelets are low today, but not really low. We could hold off until tomorrow to transfuse, if you can come back to the clinic then. He's losing weight; we should consider an NG tube. And on and on and on.

These are all the meaningless choices. Not meaningless in the sense that they are unimportant. Do a good job on all the day-to-day stuff and it can have a big impact in your child's comfort and your peace of mind. Make all the wrong choices, though, and it won't likely have any effect on the final outcome. In that sense, they're all meaningless.

So of all the impossible and meaningless choices that you get to make, is control just an illusion? Isn't it just one great train ride you are on, and at some point you pass a switch in the track that determines your final destination?

That might be true. But there is one other choice you get to make that does have a lot of meaning. It may or may not affect the destination, but it certainly does affect the ride. It's not even an obvious choice, because nobody will ever present it to you. You don't have to sign the consent form. You don't even have to announce your decision.

You get to choose how miserable you want to be.

OK. Life sucks. Your kid has cancer. But every day you get to choose if you want to be pessimistic or optimistic. You get to choose whether you want to be a victim or your kid's biggest champion. You get to choose if you want to endure the day or have some fun and make the best of it, whatever it brings you. You get to choose what example you want to set for your kid. And you get to choose whether you want to teach your kid that he has a choice of whether or not to be miserable.

It's a choice that you actually get to make a dozen times a day in different circumstances. And you don't always have to make the "happy" choice. Sometimes it feels really good to just have a bad moment and tear the head off the incompetent idiot who appears not to have the skills to issue your parking pass.

Once you realize that you actually do have control over just about everything in your life, except perhaps the impossible choices and impossible outcomes, it makes the journey a whole lot easier.

You might still be rattling down the railroad, but if you believe you're flying the space shuttle, you might actually have a better chance of reaching escape velocity. And it's a whole lot more fun to eat astronaut food.

Steve Dolling is a husband and father of two boys. He lives in Port Coquitlam, BC, and writes pediatric oncology humour in his spare time. His ten-year-old son, Spencer, is battling neuroblastoma.

The White Door

Barbara F. Lefcowitz

For Dr. P.

For some reason this morning
I looked back at your closed white door,
so featureless, though its message was clear:
time's up. I've got other things to do,
other sad people to convince
they're not so sad as they feel,
if only the part of their brain
once called heart could bind with
their thoughts; it takes time,
a whole lifetime for some.

Still the closed door kept telling me
I don't want you. Leave.
Which I did, glad you must feel glad
that I'm gone. It would take me a lifetime
to convince you that's true. Once more I must
spin the flax of sadness to gold tassels
that would relieve the gloom of rabbinical black
until snapped threads sting back at my hands.

My Fear

I admit my great fear
of those who abandon me,
my absence barely noticed, if at all

The girl with my name who smiles from a frame
My shadow that shifts with the light's changing angles
Shipmates who suddenly jump from the rails
Anyone who bolts the door between us and walks away whistling

Whether they leave
out of boredom,
illness, death,
the need to shed memories,
escape the threats I somehow kindle;
no discernible reason at all

Afraid because my envy is autocratic
fierce as an infant's rage for sweet blue milk
Because my gods not only wear scuffed shoes
but have many other worshippers
whom I could kill in a moment—

Because I fancy I am more important than I am
a presence eternal as a fixed star
at the same time a burnt-out sun
its power stifled by its own wild fires

The Virus Empire

Who can resist admiring
the image display
at the grand bazaar of enlarged
and brightly coloured viruses,
electronic gem-scapes in every shape,
texture, architectural mode?

As with other enticements
ringed by faint shadows of threat
we try to tame them by granting names,
euphonious as Papilloma, evocative
of doves and the song La Paloma;
Salanga, the beat of a Latin dance;
the quasi-Irish Dulcamara; exotic
young ladies named Varicella, Candida,
Carposina, residents of far-off Abadina
and Aletia, islands too remote to visit

And we seek out resemblances
to what we've seen before:
thorny yellow golf balls, spiked plums,
green helical rods swimming like watersnakes,
turquoise and fuchsia turtle shells.

Lured by the microscope's
illusions of amplitude, we forget
that viruses are deadly,
secretly invasive, self-replicating,
stubbornly resistant to annihilation,
their capsids or protein coats
providing armour knights would envy

Forget how something so small
can conquer all living persons and things,
how the great virus empire,
its invisible battalions nonchalant
about the meteors and missiles everyone fears,
relentlessly drives toward omnipotence.

Barbara F. Lefcowitz, PhD, has published poems, stories and essays in over 500 journals. She has won fellowships and awards from the National Endowment for the Arts and the Rockefeller Foundation. She lives in Bethseda, MD.

Perspective: Happily I Think on Thee

Laurie Rosenblatt

> Sexual love is undoubtedly one of the chief things in life, and the union of mental and bodily satisfaction in the enjoyment of love is one of its culminating peaks . . . [A]ll the world knows this and conducts its life accordingly; science alone is too delicate to admit it.
>
> —S. Freud

At the end of a brief appointment with a widower I had treated for three years in infrequent meetings limited to the management of medication, he opened the door, turned back, and said, "You know, I am in love with you," and walked out. Shocked and flattered, I was relieved he'd gone. I had no idea what to say. I felt ashamed and thought about what I'd done wrong. Other than managing his medications, I had no treatment contract with this patient that would have provided a structure for discussing his feelings. They were just there.

When a patient expresses love or affection for the doctor, both the patient and the unprepared doctor can be thrown into confusion. In the case of delusional love, consultation and termination of the medical relationship may be necessary. But many non-delusional patients also have sexualized tender feelings for their doctors that may develop when the integrity of a patient's body and/or identity are under attack. Freud described his own experience as follows: "There is a complete change of scene; it is as though some piece of make-believe had been stopped by the sudden irruption of reality—as when, for instance, a cry of fire is raised during a theatrical performance. No doctor who experiences this for the first time will find it easy to retain his grasp on the situation."

Affection in the medical relationship may feel like love in other aspects of life, but it is rooted in extremes of dependency, helplessness, idealization, hope, and desperation. Love can develop from affection in the context of terrifying changes in the patient's sense of self or physical status. Feelings of sexual attraction then arise as an attempt to deflect attention from intolerable reality, to take a break from illness, and to reclaim health and a sense of integrity. If the patient's seeming avidity for a sexual encounter is met with tact, the doctor's response can reassure the patient about the safety of the relationship—in particular, about the physician's continued, undistracted focus on treatment. In addition, the patient's acceptance of gentle limits reassures the doctor and allows the treatment to continue.

Kay,* a woman with advanced breast cancer whose husband had left her during the course of her illness, spoke about falling in love with her male oncologist:

After they found the mets, I knew I didn't have much time. But I've been thinking, it doesn't matter how much time you have. The point is that it comes to an end. Most people are running around acting as if they've got infinity here. Now the whole death and dying thing is in my face. I'm thinking, Okay, where's it going next; what am I going to do?

So I decide to go to a new oncologist, Dr. C. My friend referred me. She said, "He's so sweet. You'll love him." And I'm thinking, I doubt that seriously. Doctors are the bozos of the universe, as far as I'm concerned.

Now, I've just had these mets and I'm in the middle of a divorce, I've had to quit work, and I meet this guy, this doctor. He's intelligent, nice, gives you the sense he's got all the time in the world. Then he prescribes the exact thing the other bozo gave me three years ago—chemical castration—hormonal treatment. This kind of treatment drives me out of my body. My body becomes an uncomfortable, painful place. I cease to exist. So I call my herbalist friends, and we do a sexuality workshop. And the next day I have this outrageous hour-long phone call with Dr. C.

There was so much . . . something . . . going on. And it wasn't just me. He's

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*Kay is not her real name. Permission has been obtained to quote from her diary.

married with three children. So, I kept thinking, No, no, no. But there was this part of me that was just, "Wow." Outrageous.

It was a simple conversation. He said, "You'll have to go up to the infusion room."

And I said, "I really hate those places. I don't do television."

He said, "Well, you could listen to your Walkman."

And I said, "Can I? And what do you listen to on your Walkman?"

He said, "Ella Fitzgerald."

And then I can't stop thinking about this doctor for the next four days. And I'm thinking, This is crazy. I'm going out of my head. My God.

Kay has lost the sense of herself as a woman, has lost her husband, and faces a shorter life. She begins to seek an antidote to, or a distraction from, these punishing realities. She looks for reassurance that she can still be whole and attractive—anything that can provide a feeling of being alive:

So next appointment, I'm late. I'm getting ready for my appointment with him—I have this little leopard dress. I mean, I'm going out on a date! And I'm talking to myself, "No. You're going to a doctor's appointment, girlfriend." So I get all dressed up and I drive in, and I hit horrible traffic, so I'm really late. When I get there, I run up to the desk and I say, "I am so sorry I'm late for my appointment with Dr. C. I hope I haven't held him up, because I know he's really busy."

And the woman at the desk says, "He never sees patients today. You're his only appointment."

Kay finds Dr. C. smart and caring. She hopes he can help her live longer with a disease that she knows will kill her. And Dr. C. is genuinely concerned about her as he focuses on trying to help. These expressions of care on his part serve as the very real foundations on which she has based her attraction.

Love founds—and may founder—the treatment alliance. The love of the patient for the doctor engenders compliance and endurance of difficult and extended treatments. Affectionate feelings lead to acceptance of the explanations and plans for care, and allow a patient to trust in the doctor's judgment.

In addition, doctors want to be respected and admired, and we offer our caring to patients who hope to be healed by our treatments. A patient's love may then become very important to us, reflecting our own aspirations to provide the knowledge and healing for which the patient longs. We may then feel that with these patients we are in reality the super-competent, omniscient, and effective physicians we desire to be. But our affectionate caring for our patients is by its nature bounded and insufficient, often leaving our loving patients ashamed of their needs, their disappointment, and their longing to be saved by the doctor's love. The patient's love may then become oppressive for both patient and doctor.

Kay describes another appointment:

He walks in. I'm standing at the door. I turn around, and I mean the look on my face must just have been . . . and he totally goes into doctor mode. "Okay, we've got the results back." He sits right down. I can hardly breathe.

I'm looking at him, and he's not at all what I remember! He's kind of short, and portly—not my type at all. He's talking a blue streak. I'm hearing nothing. I'm panting. He says, "I'm getting on the computer." He shows me one of my lab reports and a note.

So I say, "That's not very interesting."

He's talking very fast and playing with a paper clip—turning it over and over between his thumb and finger. Suddenly he says, "Okay, I have to examine you. Would you please get on the table?"

I'm thinking, No. This can't be happening.

I get on the table. And he puts his hands on the back of my neck. I say, "What are you doing?"

"I'm checking your lymph nodes."

So I say, "Can I check yours?"

He pulls back, "No," and the phone rings.

It was too much. And I'm stuck thinking, What is going on? What's the protocol? How do you talk about this? Is this discussed? Does it matter?

Then he's business as usual, appointment's over, and we walk out. I look at him and ask, "Are we done? I don't even get a handshake?" And he puts his hand out. And I shake it.

When it becomes sexualized, love can disrupt the patient's pursuit of treatment in favour of the pursuit of love itself. Patients may begin to feel controlled by the illness and by the physician. They may fear disappointment, and may feel defective and angry about the changes caused by illness.

Ironically, patients may then use love to fight feelings of oppression and the aggression they perceive on the part of the doctor. And in a certain sense, love makes a good weapon: it turns the tables on seemingly distant, powerful, and healthy physicians by engendering in them feelings of anxiety, helplessness, and even defectiveness.

Sometimes physicians may be surprised and threatened by their own powerful reciprocal feelings and desires. After all, a person in love exerts a certain fascination in part through fulfillment of the desire we have to be understood as special enough to be worth pursuing under prohibited conditions. Or patients we've treated for a long time can become special projects for us. The patient can become someone toward whom we feel compelled to make reparations. And if treatment fails, we may react with intense feelings of guilt, disappointment, and shame—may even abandon the patient at a critical moment. At a minimum, patients can threaten their doctors' sense of themselves as ethical practitioners as they seek reasons for patients' loving feelings in their own real or imagined missteps in maintaining the proper boundaries. For instance, Dr. C. might think about his minor boundary infractions—the hour-long phone call, his mention of Ella Fitzgerald. And, in view of Kay's vulnerability, he decides to see her during regular clinic days, and will ask a nurse to join him during all visits with Kay.

Patients and doctors each bring to the relationship a level of formality that they find comfortable. But they may need to adjust their boundaries as the relationship develops. Kay comes with an informal style, making it necessary for Dr. C. to heighten his formality in response. When patients cross such a line, their doctors risk having each gesture observed carefully and encoded into love's semaphore. In their attempts to regain a more comfortable distance and to retain their focus on medical treatment, doctors risk humiliating patients by refusing to love them in return.

Later, Kay tells about receiving Lupron and quickly losing her sexual desire. She calls and leaves Dr. C. a message asking him to call back. She reports their conversation as follows:

"Hello. It's Dr. C. How are you doing?"

I say, "I'm doing awful. I've become a sexless cow. I want no part of this."

He says, "Whoa, whoa, whoa, wait a minute. What's going on?"

So I say, "I can only explain it in poetry. In the middle of Kunitz' poem 'Touch Me' there's a part that goes,

'What makes the engine go?
Desire, desire, desire.
The longing for the dance
stirs in the buried life.
One season only,
and it's done.'"

And he says, "Are you talking about libido? We really need to talk. Please stay on the Lupron and try."

And that was as good as it got; he would go the distance. The man is incredibly intelligent—I absolutely adore that about him—but there's something else going on.

Dr. C.'s concern about Kay's well-being, his understanding of the way her feelings are changing under the pressure of illness, his treatment of her experiences as normal and important, and his constancy have helped to stabilize her and make her feel more intact—more herself.

Kay reflects,

I've been praying for someone to come and distract me from Dr. C. because it's just not appropriate. And yet, what else gives us juice? When you're confronted with a life-destroying illness, you need everything that's life.

In the context of a relationship organized around diagnosis and treatment of physical illness, deeply personal involvements can occur between physicians and patients. Most of these involvements facilitate care and don't need to be carefully thought about or to be discussed with patients. But the affectionate feelings that help patients endure life-changing treatments, forgive our mistakes, and maintain their trust in our care may, in circumstances of extreme illness or psychological vulnerability, also cause physicians pain, confusion, and anxiety because of the patients' apparent disregard for the realities of our relationships with them.

At those times adjusting our own levels of formality and providing a safe environment for ourselves and our patients by consulting colleagues, paying attention to timing and structure of visits, and having the visits chaperoned are usually effective methods of managing sexualized affection in the doctor–patient relationship.

Acknowledgement

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Laurie Rosenblatt practises psychiatry at Dana Farber Cancer Institute and teaches at the Harvard Medical School. Dr. Rosenblatt has published patient narratives in creative non-fiction journals, and in books on the subjective experience of illness.

For David: After Words

Susan Cox

Even if you can't talk, you speak
and even if you are not here
i want you to know i am listening

i will never say i know because i don't and can't
i am caught up in thinking
about the meaning of contemplating not being able to speak
not being able (as you say) "to communicate well"

what does it mean?
to come to know this outside in and bit by bit
a syllable at a time
as words slip and slur
and only those who know the you you were
(and still are but are unable to say)
must try ever harder
to
hear
you
never pretend to understand your meaning
only repeat the fragments
in exchange for your look
your look that says "try again"
"try some more"
"try until I think you understand something"
"some part of what I am trying to say"

(you watch as i think i hear you and nod "okay you may go on")

there is much more in this awkward loss than i know how to say
how can you say what it means to be unable to say?

and coupled with this
coupled with this is one way of knowing that says
you cannot survive
you cannot survive this disease
but you are still here
and the want for words wrestles sleepless in these pages
choking innocent sheets

breathless
indelible
this loss

i can't say what it is
but to be with it and in it
cloaked heavy with trying
knowing it like the skin on the back of your hand
in grace and time
and precious time

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THE CANADIAN POLIO EXPERIENCE

A Personal Journey through the Past

Christopher J. Rutty

"Polio is the worst cold there is."[1] So confided five-year-old Neil Young to his father, Scott Young, after encountering polio in Omemee, Ontario, in the late summer of 1951. Reading the personal polio story of Canadian music icon Neil Young, as told by his father in his 1984 *Neil and Me* dual biography, was the beginning of my personal polio story. Yet my story is not like those collected by Sally Aitken, Helen D'Orazio, and Stewart Valin in their *Walking Fingers: The Story of Polio and Those Who Lived with It*,[2] two of which are reprinted here. I never got polio, nor did anyone close to me, but it has clearly had a powerful effect on my life as a historian.

As a means of providing some historical context about the Canadian polio experience, but rather than simply writing a summary of the main elements of the epidemic and early vaccine eras, and in keeping with the flavour of the *Walking Fingers* extracts, I thought a personal approach would be more appropriate. I was also inspired by Michael Bliss's confessional article in the premier issue of this journal about how he arrived at being a medical historian.[3] Moreover, there are several recent summaries of the Canadian polio story available in print—including the *Walking*

A physiotherapist at the Sudbury General Hospital uses a doll at the end of walking bars to encourage two-and-a-half-year-old Gifford to walk. His valiant effort symbolizes what thousands of other Canadian polio survivors have also endured to overcome the crippling effects of this disease over the past century. *National Archives of Canada.*

Connaught Laboratories took on a Herculean role in 1953 and 1954 to supply all the poliovirus fluids used to make the Salk vaccine that was subjected to the largest field trial in medical history. *sanofi pasteur limited (Connaught Campus), Toronto.*

Fingers volume and articles in the *Canadian Journal of Public Health*—and on the Web,[4] and it thus seemed redundant to repackage such pieces here. Rather, it may be of more interest to highlight key elements of the Canadian polio story as I discovered them by tracing the journey through the past that I have taken since 1988, when I first started researching this "middle-class plague." This phrase, incidentally, is also the main title of my own book on the Canadian polio years that I expect will be finally published by the University of Toronto Press in 2006.

I was born in 1962, several months after the Sabin oral polio vaccine (OPV) was launched in Canada, and seven years after the Salk inactivated polio vaccine (IPV) was introduced with much fanfare on April 12, 1955. Thus, I had little direct experience with the pre-vaccine polio epidemic era, or its aftermath, except for vague memories of a few kids in leg braces when I was in elementary school.

I hadn't thought much about polio until I read "Polio Was a Killer and Neil Had It" in Scott Young's *Neil and Me*. In 1984, I discovered Neil Young's music and remember being fascinated by his polio experience, in addition to the other health challenges he and his two boys had faced. In early 1988, I took a course in the history of science and medicine in Canada at the University of Western Ontario, and when it was time to pick a topic for a major essay, I immediately thought of centring the project on some aspect of Neil Young's health challenges. I enjoyed mixing my personal interests with essay topics during this period, so using Neil's personal experience with a disease, such as epilepsy, or cerebral palsy (which his two sons developed, even though they had different mothers), or polio, seemed like a fruitful basis for a historical essay.

While Scott Young had vividly described Neil's polio experience, especially by including a detailed narrative in *Neil and Me* that he wrote shortly after Neil had returned home from the Hospital for Sick Children, I couldn't only recount Neil's personal experience with this disease. I quickly discovered an almost complete absence of secondary historical literature on polio in Canada. Thus, I utilized primary research skills I had developed during courses and collected medical journal articles about poliomyelitis published in Canada in and around 1951, as well as medical books on the disease. I also spent time reading through and taking notes from microfilms of Toronto newspapers published during the summer and fall "polio season" of 1951 in search of reports about the epidemic that was occurring in many parts of Ontario.

According to Scott Young, Neil's polio case was the first in Omemee that year, and was the more famous because he didn't die, unlike the second. While the 1951 appearance of polio in Ontario was serious, it was not the worst polio epidemic the province had endured. It was actually more like a severe outbreak, which is how I described it in an essay, "Helpless: The 1951 Ontario Polio Outbreak—The Neil Young Case."[5]

My professor for the course, James T. H. Connor, suggested that I continue to research and write about the history of polio in Canada, as it was clear that there was very little published on the topic. Indeed, in his comments he wrote, "I think you might be able to expand on this whole idea sometime in another major project." He also confessed, "This essay

A class for young polio patients at Sick Kids, 1948. *The Hospital for Sick Children (Toronto), Hospital Archives.*

was graded while listening to my original 1970 pressing of *Déjà Vu*." This was the album on which Neil Young, as part of Crosby, Stills, Nash, and Young, originally recorded his "Helpless" song, which I felt was at least in part inspired by his childhood polio experience. Someone then suggested that the essay be published in the UWO student history journal, the *Mirror*.[6]

As a fan of Neil and a member of the Neil Young Appreciation Society, and after mentioning my essay to the editor of its fanzine *Broken Arrow*, I was asked to submit it for publication. It appeared in the August 1989 issue and was also reprinted in *Neil Young and Broken Arrow: On a Journey through the Past*.[7] The unusually detailed text and footnotes (for a fanzine) attracted the interest of fellow fans who hadn't been aware of this part of Neil's personal history, or of the dramatic severity of epidemic polio before the first polio vaccine was available.

A year later, during a special directed projects course during my fourth year, I acted on Professor Connor's suggestion. Being in London, and aware of the severity of Ontario's worst polio epidemic in 1937, I decided to examine how this major public health crisis affected the London region. Through the London 1937 essay I was introduced to a selection of local and provincial government public health records, and I also developed an interest in how the popular press covered polio epidemics in Canada.

However, as I concluded in the paper, "One can only suppose that London's experience with poliomyelitis in 1937 was representative of other localities across the province, at least generally. One suspects, however, that a more detailed study of the provincial situation would reveal some interesting differences between the way individual cities and towns managed their local experience with a disease such as poliomyelitis." I then added, "Hopefully this particular examination of the London area in 1937 is but the first step towards a fuller understanding of how poliomyelitis impacted upon Ontario and upon Canadian society generally."[8] I did not know it at the time (March 1989), but that would be the course I would soon follow with this subject. I *did* know that my next polio history project, a master's thesis in history at UWO, would focus on the province of Ontario more broadly, although mainly on the cities of London and Toronto during the 1937 and 1953 epidemics, comparing their responses, with a focus on how the press coverage of the disease influenced how the medical profession managed the disease.[9]

Researching my master's, undertaken under the supervision of Professor Connor during 1989–90, and with the financial support of a Hannah Institute for the History of Medicine graduate scholarship, allowed me to look more closely at what I described as the "hopeful polio weapons" of convalescent serum and a preventive nasal spray, the potential value of which was much touted in the Toronto and London press during the 1937 epidemic. I also was able to contrast how the Canadian medical literature and the popular press in each city approached, described, and increasingly debated these therapeutics that were available to physicians, albeit only through the provincial government. More generally, I was also fascinated by the ironic aspects of polio, especially how it became a growing epidemic threat after the late nineteenth and early twentieth centuries precisely because of the improving public health and

The challenge of walking with two sets of braces. *Shriners Hospital, Montreal.*

hygiene infrastructures that had proved so important to the control of most other infectious diseases.

While the master's thesis allowed me to more closely research the press, the medical literature, and the Toronto, London, and provincial records related to the Ontario polio epidemics of 1937 and 1953, it was clear that I could do more. In particular, I had not focused as much on Ontario government health records as I had on the city level, nor had I looked very much at the history of the Salk and Sabin vaccines in Canada.

After shopping around among universities in Ontario in search of a PhD program, the University of Toronto was the school at which my wife was also able to find an acceptable graduate program in geology. The History Department at the University of Toronto, and, in particular, Professor Michael Bliss, seemed interested in my previous work and in supporting and supervising my plans for a national study of polio in Canada for my dissertation.

My PhD program started in Toronto in September 1990, almost immediately after my MA thesis defence in London. However, I would have little time to focus on researching my thesis during the first two years of the program, the major part of which was preparing for comprehensive exams in Canadian history, Canadian medical history, the history of medicine, and early modern British history. I also had to work as a teaching assistant in undergraduate Canadian history courses, although other than the history of science and medicine in Canada course, and a course in Ontario history during my master's, I had not taken a Canadian history course since Grade 10. Now I was not only majoring in Canadian history for my comprehensive exams, I was also teaching this subject in undergraduate tutorials and marking student essays and exams. Despite this crash course, I quickly learned more than I expected about the history of Canada, much of which proved useful for understanding the broader social, economic, political, and international context in which the Canadian polio experience developed.

In my dissertation I planned to tackle the history of polio on a truly national scale and over almost a century of time, but in particular, the 1927 to 1962 period, in a fairly chronological structure. Such national Canadian historical studies were not particularly fashionable at the time. Most historians preferred to focus on particular regions of the country,

This cylindrical cage, which allowed the patient to breathe and, in many cases, to survive, was a miraculous technological gadget for those imprisoned within it for a number of weeks or months, if not for the rest of their lives. *The Hospital for Sick Children (Toronto), Hospital Archives.*

narrower time periods, and confined thematic analyses of such issues as class, gender, or economics. Professor Bliss, one of the few historians calling for more national perspectives, supported my approach, which was a significant leap from the provincial master's thesis. By the time I was free to begin full-time research in the fall of 1992 (thanks to graduate scholarships from the Hannah Institute), I was ready to venture into several new research directions. My initial focus was to find out how provincial and federal health departments approached and responded to major polio epidemics.

After spending considerable time in the Ontario Archives, followed by almost a full month in the provincial archives of Manitoba, Saskatchewan, and Alberta, and then taking several trips to the National Archives in Ottawa, I quickly realized how seriously Canadian governments took the growing problem of polio during the pre-vaccine and pre-medicare eras. Specific provincial polio treatment and hospitalization policies were developed after major polio epidemics in most provinces. There was even a *Poliomyelitis Sufferers Act* in Alberta, first enacted in 1938, which provided for free polio treatment and hospitalization to all polio patients.

Time and financial constraints prevented similarly intense research trips to British Columbia, Quebec, and the Maritimes, although the comparatively lower incidence of polio in these regions allowed me to focus my research resources in Ontario and the Prairies, where Canadian polio epidemics were most intense. My research trips to the National Archives, and considerable interprovincial correspondence available there, among other published and unpublished sources, provided substantive documentation on how the other provinces managed the disease. Fortunately, my Hannah scholarship allowed me to be quite liberal with ordering photocopies during my research trips, especially since this was before I bought my first laptop computer, and my handwriting was not the neatest.

As important as the provincial and federal government records were to the development of my understanding of the Canadian polio story, the most significant body of primary documents I was able to access was the archival collection held at Connaught Laboratories in Toronto, which was a self-supporting part of the University of Toronto from 1914 through 1972. After 1989, Connaught Laboratories Limited was the Canadian component of Pasteur Mérieux Serums and Vaccines, based in Lyon, France.

The materials I collected from the provincial and federal archives were publicly available, although I often needed permission to access them because, as I was the first historian to use them, they had yet to be reviewed. Others could have done the same to access them. For the archival materials available at Connaught, I received valuable cooperation from the librarian, Hugh McNaught, and the director of Public Affairs, Don McKibbin. Both had a strong interest in preserving and sharing the history of the company and thus welcomed my interest in researching the history of polio, especially Connaught's central—though little-known—role in the development of the Salk vaccine. Hugh and Don had also each joined Connaught in the late 1980s and had been active in starting a Connaught Heritage Committee, a main focus of which was finding and preserving historical artifacts and documents of the lab's work in order to eventually set up a Connaught Museum.

My experience in 1992–93, while reviewing and photocopying (for free, thanks to Hugh) an extensive collection of well-organized files documenting Connaught's polio research and vaccine development, was quite different from Michael Bliss's experience with Connaught a little more than a decade earlier when he was researching the history of insulin. At that time Connaught's archives had not yet been assembled, organized, or catalogued, a project undertaken through the leadership of a former director of Connaught, Dr. R. J. Wilson, in 1982, which was when Bliss's *Discovery of Insulin* was published. His book thus has relatively little to say about Connaught's significant role in the early development and large-scale production of insulin.

While I was able to develop a detailed understanding of how Canadian scientists at Connaught contributed to unravelling the mystery of the poliovirus, and, more importantly, developed key technologies to make the Salk vaccine possible, of broader significance was recognizing Connaught's central place in the evolution of Canada's public health system. My polio-related research at Connaught, supplemented with the documentation at the National Archives and in provincial archives, was the key to developing a cohesive national understanding of the Canadian polio story.

From 1914, and especially between 1927 and 1955, Connaught, and the intimately connected School of Hygiene at the University of Toronto (they shared administrations and facilities), educated almost every local, provincial, and federal health officer, or deputy minister across Canada, not to mention epidemiologists, virologists, and other public health personnel working in Canadian health departments. They generally knew each other and tended to share the public health vision of the founder and first director of Connaught and the School, Dr. John G. FitzGerald, and his successor in both positions, Dr. Robert D. Defries.[10] Defries, in particular, personally oversaw Connaught's essential role in supplying all the bulk poliovirus fluids used to prepare the vaccine used in the massive Salk vaccine field trial in the United States (and parts of Canada) in 1954–55.

As important as Defries was to the Canadian polio story—and as was true south of the border with Franklin D. Roosevelt's personal encounter with polio in 1921, his rise to the presidency despite it, and his establishment of the National Foundation for Infantile Paralysis—Paul Martin's personal and family experience with this disease was critical to its management and control in Canada. The extract from *Walking Fingers*, published in this issue, provides details about these events from the perspective of Paul Martin Jr., who, like his father, also contracted polio, which struck him in 1946 when he was eight years old, just a few months before his father became minister of national health and welfare.

The personal polio experiences of both Paul Martins and of FDR underscored what is perhaps the central element in my understanding of the distinctive impact of polio during most of the twentieth century. Polio was, and in many ways remains, a distinctly middle-class plague, the public-health, political, and scientific response to which was driven by its sudden and long-term personal, social, and economic threat to the children and families of this dominant segment of the population. This distinctive aspect of poliomyelitis was recognized in Canada as early as 1912 by child health authority Dr. Helen MacMurchy: "Often the vigorous and healthy are attacked and those who have comfortable homes and good care . . . Theirs is the sad fate of the disabled, who must go on life's rough way never able to walk as well again, never to skate at all, or to dance or to run. It is hard." Indeed, as she noted, the head of one of the largest industrial corporations in the country, as well as a professor at Queen's University, fell victim in 1910 during Canada's first major outbreak of polio, or, at the time, more popularly and misleadingly called "infantile paralysis."[11]

I discovered McMurchy's 1912 *Maclean's* article, "Paralysis: The New Epidemic," after I had defended my PhD in 1995,[12] when I was first able to dedicate significant time, thought, and energy to transforming my dissertation into a publishable book. I had undertaken an initial revision for the University of Toronto Press shortly after I completed the thesis, but was unable to satisfy external reviewers that it was ready for publication. By the fall of 1999 when I returned to the manuscript, I decided to begin the Canadian polio story in 1910, rather than in 1927, and also take it up to the present. I managed to capture the early part of the story during the summer and fall of 1999, but could not tackle the post-1962 material until 2004, thanks to the support of another key person at what is now the Connaught Campus of sanofi pasteur limited, Dr. Luis Barreto, vice-president of public affairs, who has a particular interest in the history of polio and eradication of the disease. Building on a historical consulting relationship I had developed with Connaught since 1995, I was able to obtain some financial support from Dr. Barreto so I could focus on the revisions and new research and writing. He also ensured that I continued to have free access to the Connaught Archives, including a much more extensive collection of off-site documents than I had used in my original dissertation.

Thus, recognizing polio as a particularly middle-class threat—not only during the epidemic and early vaccine eras, but also as a threat that drove the global polio-eradication program, as well as the grassroots and voluntary efforts to manage the challenges of post-polio syndrome—has shaped how I now understand this disease, particularly in the Canadian context. For readers of the personal polio stories collected in *Walking Fingers,* and those selected for publication here, I hope my personal journey through the past as a polio historian, and how I have grown to understand polio's broader Canadian impact since first reading about Neil Young's case, will help them better appreciate how polio has affected and continues to shape the lives of thousands of individual Canadians.

Notes

1. Scott Young, *Neil and Me* (Toronto: McClelland and Stewart, 1984), 36.
2. S. Aitken, H. D'Orazio, and S. Valin, eds., *Walking Fingers: The Story of Polio and Those Who Lived with It* (Montreal: Véhicule Press, 2004).
3. M. Bliss, "Growth, Progress, and the Quest for Salvation: Confessions of a Medical Historian," *Ars Medica* 1 (Fall 2004): 5–14.
4. See, for example, C. J. Rutty, "The Twentieth-Century Plague," *Beaver* (April–May 2004): 32–37; C. J. Rutty, L. Barreto, R. Van Exan, and S. Gilchrist, "Conquering the Crippler: Canada and the Eradication of Polio," *Canadian Journal of Public Health* 96 (March–April

2005), special insert; www.healthheritageresearch.com/poliohistory.html.

5. C. J. Rutty, “Helpless: The 1951 Ontario Polio Outbreak: The Neil Young Case” (essay, University of Western Ontario, April 7, 1988).
6. C. J. Rutty, “Helpless: The 1951 Ontario Polio Outbreak: The Neil Young Case,” *Mirror* 9 (1989): 82–109.
7. C. J. Rutty, “Helpless: The 1951 Ontario Polio Outbreak: The Neil Young Case,” ed. A. Jenkins, *Neil Young and Broken Arrow: On a Journey through the Past* (Mid Glamorgan, Wales: Neil Young Appreciation Society, 1994), 95–112.
8. C. J. Rutty, “The 1937 Ontario Poliomyelitis Epidemic: Its Infection, Spread, and Management in the London Region” (essay, University of Western Ontario, March 31, 1989).
9. C. J. Rutty, “‘A Grim Terror More Menacing, More Sinister than Death Itself’: Physicians, Poliomyelitis, and the Popular Press in Early 20th Century Ontario” (master’s thesis, University of Western Ontario, 1990).
10. James FitzGerald, “Sins of the Fathers,” *Toronto Life* (February 2002): 66–72; J. FitzGerald, “The Troubled Healer,” *University of Toronto Magazine* (Spring 2002): 86–93; C. J. Rutty, “Robert Davies Defries,” in *Doctors, Nurses, and Medical Practitioners: A Bio-Bibliographic Sourcebook*, ed. L. N. Magner (Westport: Greenwood Press, 1997), 62–69.
11. Helen MacMurchy, “Paralysis: The New Epidemic,” *Maclean’s* (November 1912), 110.
12. C. J. Rutty, “Do Something! Do Anything! Poliomyelitis in Canada, 1927–1962,” (doctoral thesis, University of Toronto, 1995).

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Like Father, Like Son

Paul Martin Jr. and Paul Martin Sr.

Paul Martin, Jr., wanted to talk about his father, Paul Martin, Sr., because his father's life had been greatly affected by polio, whereas his hadn't. His father will always be remembered for the courageous stand he took to keep the Connaught Labs and their vaccination and dissemination programs going in the spring of 1955. The Salk vaccine had just been released, but in the United States, children were getting polio from it. The problem was traced to the Cutter Lab in California. The urgency of combating this scourge had led to too much haste in production and it was discovered that the formaldehyde bath given the live virus for the vaccine was being withdrawn prematurely. The U.S. program was temporarily shut down. But Paul Martin, Sr., in his role as Minister of Health, was advised that the Connaught vaccine was safe, so he boldly gave the go-ahead for Connaught Labs to continue with its production and dissemination of the vaccine. Thus countless new polio cases in this country were avoided. It was a decision that took heroic courage on his part and confidence in his advisers. Had he misjudged, his career would have come to an abrupt end.

Paul Martin, Sr., played an important role in the Liberal ranks because of his impressive educational background in philosophy, international relations, and law. He had been appointed Parliamentary Assistant

Inauguration of the polio lab at the Institut Armand Frappier, April 21, 1956, for the production of the Salk vaccine. Dr. Armand Frappier, Mgr. Irénée Lussier, Paul Martin Sr., Quebec Premier Maurice Duplessis, and Dr. Vytautas Pavilanis beside a rotating drum of vaccine. *Institut Armand Frappier.*

to the Minister of Labour in 1943. He entered the Cabinet in 1945 as Secretary of State and in 1946 became Minister of National Health and Welfare. In spite of the government's increasing conservatism on social issues, he managed to introduce a system of health grants, and by threatening resignation, made Prime Minister St. Laurent accept national heath insurance. This has been invaluable to all those with chronic illness, amongst whom are many old polio patients.

Long before Paul Martin, Sr.'s death in 1992, his genius for leadership was being equaled by his son, Paul Martin, Jr. Now Prime Minister of Canada, Paul Jr. said, "This is going to be a somewhat sketchy story because

Headline, *The Telegram. Courtesy of Polio Canada.*

I had polio a long time ago, in 1946, when I was eight. I remember very little. There was a big epidemic in Windsor that year. In the summer of 1946 I was playing down at the beach. Coming home, I felt as if there was a plate in my stomach. My mother rushed me to the hospital."

In the 1940s polio put the fear of death into not only parents, but their children also. People would keep their distance in case the afflicted person was contagious, which left him or her with a terrible sense of isolation. However, Paul Martin, Jr., remembers nothing like this. "Whatever they did to me in the hospital, I made a complete recovery, complete enough to be back in school after Christmas. I simply can't remember how long I was hospitalized, but am told that I had a very severe case of polio that affected my lungs. It was thought I wouldn't make it. I must admit that it is difficult to separate my personal experience back then from what my mother told me.

"I was apparently watched for two years; instructions had been given that I should never get upset. The end of this period signaled my last thought of polio until about seven years ago when Jan Brown, who was a Reform Member of Parliament and actively involved with post-polio, asked if I would like to go to a polio meeting in Ottawa to receive a commendation on behalf of my father from the Southern Alberta Post-Polio Support Society. Commendations were also being given that day to Dr. Salk and the Connaught Laboratories. This was the first time I had heard of the possible late effects of polio. It was at this Ottawa meeting in April 1995 that I recalled my memories of the disease for the first time in decades and saw personally by looking around the room that polio was still a challenge for many of the survivors, some of whom were affected by post-polio syndrome."

Asked if he remembered any particular anecdote related to his polio, following a pregnant pause, Mr. Martin recalled gleefully how his mother had been told that for the first two years of his polio he should never be upset. "But," said Paul Martin, "well do I remember when that two years was over. That was the end of my 'honeymoon.' She let it all out. I got absolutely killed for doing virtually nothing. Here's an example of how she spoiled me. I had lost a baseball. I remember losing it in a park, miles from home. It was my favourite baseball and I was devastated. Two days later, there was my baseball on the table. Years went by before my mother confided that she had bought a replacement for the lost ball and ripped off the cover to make it look authentic, all to appease me. I grew up like a pampered child for this period. I don't think my sister was jealous. She was so much younger."

When asked what impact polio had on his life, Paul Martin without hesitation was able to say, "I wish I could give you a deep insightful answer, but I don't really think it had any effect at all. I was fairly sick for about six months and was watched for a year and a half afterwards, and that was the end of polio for me.

"My Dad, on the other hand, was physically affected by polio. He was paralyzed down one side of his body, and was left with no sight in one eye and a very weakened arm and leg. It wasn't really noticeable unless you were to see him in a bathing suit. As a child he managed to get everywhere, but only if pulled around in a cart or sleigh. He spent about two years coming back to a functioning level. He came from a very humble Irish/French family from the Ottawa Valley. It's quite conceivable that polio made him the man he was because he was the first ever in the family to go to university and he chose that route partly because more physical futures were incompatible, given his weakened body. My grandmother was without doubt a driving force in his life because she had been a teacher and was a very strong-minded person. In those days you could teach without special training. My Dad attended Toronto University, Harvard, Cambridge, and Geneva Universities, and went on to lead a very public life."

Mr. Martin, Sr., spent thirty-nine years as MP for Windsor, Ontario, and as cabinet minister under Louis St. Laurent. Health was one of his many portfolios. He became connected to the March of Dimes in Ontario, for obvious reasons, and in 1994 the Paul Martin Senior Society was started. Monies collected went for medical research and the war against polio in particular. The Society honours those who share Paul Martin, Sr.'s vision and commitment. Since his brave decision in 1955 to carry on with the vaccine production benefited all of Canada, it might be a good idea to extend his Society and its goals across the country.

Excerpted, with the publisher's permission, from *Walking Fingers: The Story of Polio and Those Who Lived with It*, eds. Sally Aitken, Helen D'Orazio, and Stewart Valin (Montreal: Véhicule Press, 2004), 80–83.

THE CANADIAN POLIO EXPERIENCE

We Get from Life What We Give to It

Jimmy Cotter

I felt ill on a Saturday in the autumn of 1953, aged twenty. I had a headache that I believed to be a hangover. By Sunday I was perspiring with fever. My doctor insisted I go for a lumbar puncture, and sure enough, Dr. Monroe Bourne diagnosed me with polio. I was taken to the Alexandra Pavilion that afternoon where I was quarantined for two weeks. Three days after being admitted, I was placed in an iron lung where I remained for nine weeks. It looked like a big old-fashioned washing machine. Except for my head, my whole body was inside with the air pressure breathing for me. There were portholes through which the nurse could take care of my hygiene and wash me. Soft felt around these portholes stopped air from escaping. When they had to work on my entire body, they put a big plastic bubble over my head. They could then open the respirator and slide me out on a stretcher and work on me without interfering with the air pressure.

My first two weeks in the iron lung were tormented by nightmares; I was cutting my throat, or stabbing myself with scissors, and I remember the panic when under the plastic bubble I wasn't getting enough oxygen.

The nurses thought it was my just being scared, but it turned out to be a malfunction. Needless to say, it sort of destroyed my confidence in that plastic bubble. But at the Alexandra there were always nurses nearby, so if a respirator malfunctioned or there was a power outage, they would swing into action with a hand pump.

I'm still in touch with the wonderful head nurse, Laleila (Jenny) Wren. The Alexandra was a training institution; so every six weeks we would have a new batch of nurses from all the hospitals. They were kept on their toes by Nurse Wren, which resulted in excellent care. Weaning me from the iron lung took about four weeks on a chest respirator, a sort of shield like a baseball umpire's chest protector which I needed less and less over that period. From the Alexandra I was sent to the Western (Montreal General) until June 15. My ability to walk came back slowly by Christmas. My left leg regained almost normal strength, but my right leg can't bear weight when my knee is bent. I was hospitalized for a total of eight months.

Although my polio was diagnosed in Montreal, I'm not sure where it came from. I used to swim in many of the Laurentian lakes around Lac Marois. I had three groups of friends—my own personal group, the group that I worked with, and a group on the Lakeshore that I played football with. I was the only one in all these three groups that came down with polio. How do you explain that? I didn't think too much of my diagnosis because about eight years previously I had a friend who had had polio, and it was hardly noticeable. I'd never known anyone who had it more severely, so of course I thought I would soon be out of the hospital, take a holiday and then go back to work at the bank after Christmas.

I was a client of the Institut de Réadaptation from 1954 to about 1956, off and on, under Dr. Mongeau. They sent me to New York, to the Institute of Physical Medicine and Rehabilitation—Howard Rusk's Institute, part of the Bellevue Medical Center. They tried to make a brace for me here in Quebec. It was the March of Dimes back then that made it possible for me to spend nine weeks in New York where a unique brace was made, by trial and error, guided by the occupational therapist. It had a cable attached to the forearm that went up my sleeve, down my back anchored to a belt round my waist. The cable went down my pant leg to a robin's-egg-like thing attached to my shoe, like a fishing reel with a brake on it—a bar—and when I stepped on the bar, the fishing reel wound up and locked, so when I straightened my leg, it pulled on the cable and lifted my arm. It was how I was able to hold a pen or a pencil, so I could write, just by the movement of my body, by holding my arm at the desk level, and when I wanted to type I just took a pencil without an end on it and typed as you would with one finger. I could only master a limited speed. Dr. Underecker was the resident in charge of my file.

After a year, they wanted me back in New York to complete the hand-piece at Bellevue. And what a good recreational program they had, too—professional baseball games, football games, basketball, an opening at Radio City Music Hall, a championship boxing match. There were always a couple of station wagons at our disposal so that on weekends we could take off.

The man who made the brace was a paraquad, having been in a terrific car accident. However, he was a perfectionist. His, or should I now say my brace is featured in a rehab textbook, and a video has been made about it for teaching purposes. I'd only wear the brace for work. It would take ten to fifteen minutes to get me strapped into it. I don't wear it any more, though, but it enabled me to work all those years. When I had mastered it with the help of the Rehab in Montreal, they offered me a part-time job. For six years I worked half days. Then the new Institute was built and I accepted a full-time position. I was there for thirty-nine years, until January 1995 when I got pneumonia.

My pleasant memories of the hospital are those of the nurses. We were all about the same age, which made it a lot more pleasant. We talked about the same things, the same jokes. Now that I'm in a nursing home—I'm the baby here at The Bayview—I'm about the same age as many of the nurses. Makes me think of all those young nurses way back in the 1950s who were my age. What a difference it made to my hospital life.

I lifted weights. I figured it was a good thing to do, but it certainly didn't strengthen my leg. I'd learned long ago to do crossword puzzles at night without my brace, so that is now how I write.

My friends all stuck by me and still visit. If I had stayed home after my pneumonia, I would have been very much alone with just a CLSC nurse visiting twice a day. That's why I wanted to be in this nursing home—near them. It's like being in a resort—nice people and a great view overlooking Lake St. Louis. Réné Dallaire invited me out sailing last summer in Ken Francis' program, but the wind was very strong that day, so I stayed on shore, having been warned to avoid catching cold.

Paying expenses was difficult. Dad died in 1951 and my mother was just getting the old age pension. My sister and three brothers were no longer in Montreal. My mother was getting ready to sit back and enjoy life, and—Bang!—I got sick. She was the one who took care of me from 1953 into the 1970s when her health failed and we had to get people to come in. She died in 1976.

The top third of my lung didn't come back after my polio. In 1995 I got pneumonia. Tubes were thrust down my throat. They performed a tracheotomy and sent me to the Montreal Chest Hospital to recuperate. I developed sleep apnea, so was prescribed a BiPap machine. It breathes with me and should I stop breathing, after ten seconds it will pump air into me, and if I don't start after nineteen seconds, an alarm goes off and a nurse will rush in to wake me up. Tests showed that not only do I have a lung functioning at two-thirds capacity, but also that one side of my diaphragm is completely shot. The doctors determined that there was nothing that could be done surgically to mend the damage, so that is why I now have to use the BiPap to sleep. Twice a week it needs sterilizing, and the inhalation therapist comes to inspect it from time to time. My friends have been wonderful.

I lived in Montreal's Côte-des-Neiges district, and when I needed to be placed in a caring environment, they wanted to place me in that area. But my family was miles away, and my friends were on the Lakeshore. So eventually, with a social worker's help, I got transferred to Bayview in Dorval, and it's wonderful.

When I realized I was going to have to give up my way of life after the pneumonia, I soon realized that being in a place like the Bayview was so much more pleasant than being by myself at home, waiting for the caregiver. The downside of my new weakness is that I can't go anywhere without lugging this BiPap equipment with me, which I am unable to do.

Looking back, I've met a lot of new people and made new friends. I have learned that I get from life what I invest in it. Everybody is dealt a hand, and you just have to cope with it as best you can by remembering the positives and letting the negatives fall by the wayside.

Excerpted, with the publisher's permission, from *Walking Fingers: The Story of Polio and Those Who Lived with It*, eds. Sally Aitken, Helen D'Orazio, and Stewart Valin (Montreal: Véhicule Press, 2004), 126–129.

ECG

Ronnie R. Brown

The squoosh of the suction
cups will, eventually, bring to mind
thoughts of leeches, inspire
funny stories to entertain the family,
but that comes later. Now
there is only the chest pains
and the fear.

As a child she'd often stay awake, listen
to her heart's beat, sure
she'd willed conscious control. Sure
that if she stopped
listening, fell asleep
her heart would stop. Now,
she tries to slow its thumping beat,
smiles as the nurse assures,
"It's probably just a muscle spasm,
but to be sure the doctor
needs an ECG." Still,

she does worry. Worries
even as she tries for wit
when the nurse squirts
on the cream. Worries
and rattles on
about passionate squids
and alien probes
(at least the nurse
has the grace to laugh

as she flips back a breast
and presses the final electrode
into place).

"Rest normally," the nurse advises
(as if that were a possibility). Then
the room is silent except for the skitter
of the machine, the chatter of her teeth,
the drum roll deep within her chest.

"Unextraordinary," the doctor says
as he reads the graph, then adds
when she frowns, "That means normal—
a perfectly normal ECG." And she,

who has striven all her life
to veer far from the norm, heaves
a sigh. Only later, as she begins to dress
does she notice her tears
and realize just how extraordinary
the ordinary can sometimes be.

Ronnie R. Brown, an Ottawa freelance writer-broadcaster whose work has appeared in numerous magazines and anthologies, is the author of three books of poetry. Her fourth collection, *States of Matter* (Black Moss), will appear this fall.

Accident Room

Jay Baruch

Late Friday afternoon, Doc Owens phones Dr. Jack Diggs in the Pickton Hospital Emergency Department. "I'm sending a patient to your accident room, young Jack. Name is Brick Rolfson. You should know a few details before he shows up."

"Go ahead, Doc," Jack says, sounding cheerful and eager, though his spine stiffens as if bracing for a blow.

The demented, the hypochondriacs, the crazies all belong to Doc Owens. Most live in nursing facilities and group homes, the cluster of square grey high-rises overlooking the winding and slow-moving Pickton River and the red brick power plant that feeds it. Loneliness and constipation, Doc Owens believes, sit at the root of most of their complaints—from muscle pains to headaches to insomnia. If reassurance and laxatives can't improve their symptoms, he sends them to the "accident room," where the real source of the problem is often identified—a pneumonia, a bladder infection, side effects from all the medications he keeps adding on, more being better.

Accident room? An antiquated term for the Emergency Department, in this country anyway, and Jack knows he needs to set Doc straight. But he just finished his residency. He's new to Pickton. How can he make that point without insinuating that the elder clinician's skills are dated as well? So Jack squeezes the pen into the pill-shaped notepad and obediently follows Doc's story.

Brick fell from his recliner yesterday evening. This morning, Sylvie calls Doc's office, insisting her husband get looked at. He's lumbering about their second floor apartment above "Brick's Place," mentioning his lower back.

"Mentioning?" asks Jack, but Doc's story takes a detour on Brick's Place. "Every year it's voted Best Pub and Best Burger by *Night Out Pickton,*" Doc says with great pride. "You should take the wife. You can't consider yourself a local until you've eaten there a thousand times." Jack listens and waits. He can't find a neat place in the conversation to politely reroute Doc back to the problem at hand. "Did you know that Brick's left arm once hurled major league lightning?" Doc recounts warmly. "Brick made it to AAA with the Sox before being drafted into Vietnam."

"Is that so?" says Jack, by now wanting to thrust his skinny arm through the phone line and shake the starch from Doc's shirt collar. But Jack no longer works at "The Pit," the hectic and combative inner city ER where he trained. When Jack and his wife first visited Pickton Hospital two months earlier, their eyes widened as they ascended the dreamy, serpentine drive lined with landscape roses and wood chips. Even the blaring red "Emergency" sign was softened by a train of English ivy. The Pickton Medical Society welcomed Jack with a luncheon, where Doc Owens, the former chief of the hospital staff, gave him a slap on the back, a wink, and a bottle of Bordeaux, a gift that he held clumsily in his hands, like the Titleist golf clubs his wife gave him for Christmas two years earlier. She hoped he'd learn to play. He needed a hobby. Now, the golf clubs and unopened wine—gentle reminders of the expectations of others—furnish a dark corner in an otherwise spare panelled basement.

The nurse in charge of the ER nudges Jack to hang up and get moving. Patients are backing up. Jack clears his throat, a startling phlegm-dredging scrape. Doc pauses. "Excuse me," says Jack. "Did Brick pass out? Does his neck hurt?"

"No, not at all. I don't think so," Doc says, uncertain yet firm. "I added a stool softener a few days ago. Maybe that has something to do with it."

Jack scribbles the words *fall* and *soft stools.* The words dare him to make sense of them. To Jack, they reveal more about Doc's loose mind than Brick's physical condition. He thinks about Doc's oil portrait hanging in a basement corridor alongside other hospital notables, his snowy white hair, watery blue eyes, and warm smile perched between the rehabilitation unit and the staff cafeteria. He wonders what utility remains in people once they live long enough to be preserved on canvas.

"Any other problems?" he asks, hoping to bring the conversation to a close.

"I told you about his lungs," Doc says. "Tumours like golf balls. Inoperable."

"No! You didn't." Jack scratches his forehead. "Is he DNR?"

Doc Owens chuckles into the phone. "Why do you always ask about do-not-resuscitate orders? Don't you want to save anyone?"

"Not if the patient is terminal and wants to die quietly."

"Check the back, Jack," says Doc, dismissively, as if scolding a child. "Get an X-ray. Make the wife happy." His voice trails away. He tells someone in his office to "hold-on to your trousers, I'll be there in a few shakes."

"Brick overdid it," Doc Owens tells Jack. "He still works the bar every night. Believes Sylvie needs the help. But that woman doesn't need any help from anyone."

BRICK ROLFSON'S WIFE immediately corrects Doc Owens when they arrive in the Emergency Department. "He didn't fall off his chair," she snaps, her red lipstick too bold. "He collapsed getting into it." She leans forward beside Brick's gurney, adjusts the braided silver ponytail that drops down to her boyish hips. "My husband was blown off a bridge in Vietnam, sent home, and he re-enlisted. If the chair wasn't booby-trapped, he didn't fall off."

She pokes the air to punctuate each point. The sleeveless blouse tucked into a matching beige skirt reveals wiry, muscular arms. "And my name is Sylvia, not Sylvie."

"I'm sorry, ma'am," says Jack.

"I'm not a ma'am." Even with fluffy bedroom slippers she appears lean and ferocious. "Are you a doctor? You look twelve."

"Easy, Mom," says Candice, sitting cross-legged next to her mother, reading a paperback with a blurry cover. Candice is heavy, with round cheeks, and green eyes that sparkle with kindness. Or so Jack hopes. He recognizes her from Johnson's Bakery. Squeezed into the white apron, she serves up fresh breads, pastries, and lottery tickets. The tinselled shop window flanks Bruno's Cards and Things, where Mylar balloons float in the front window and XXX movies and snap-on dildos pack the back aisles. Bruno's is the only store in town that carries the *New York Times*. Jack stops by almost every morning, still tethered to what he seeks to escape.

"He was watching the ball game," Candice says. "Suddenly he stood up, stared at the television, and somehow lost his balance sitting down." She slices a Polaroid of two infants into the book to mark her spot. "He mentioned his back." Candice stares at her father with a worried expression that pleads with him to elaborate.

"What do you mean 'mentioned?'" Jack asks.

"My husband never complains," Sylvia interrupts, her voice heating up. "If he mentions something, it's bad."

Jack nods, draws a deep breath, and studies Brick lying on the stretcher, apparently content to let the conversation snake around him. He has a sledgehammer head, fleshy jowls, a bulbous nose threaded with veins. A bartender's face, Jack thinks, beaten and trustworthy. This face would lead you into inebriation and make certain a cab or friend returns you safely home.

"May I take a look at your back?" Jack asks Brick.

"Forget the back," says Brick. "Nothing's wrong with the back."

"Why did you mention it?" Jack asks, flicking a look at Sylvia, his intolerance for them primed because they belong to Doc Owens. He pauses. "What is bothering you?"

"Nothing." Brick tightens his jaw, lowers his head. He pulls away when Candice grabs his hand and tries to bring his hairy knuckles to her lips. Sylvia sits stone-faced, nodding at her slippers. Jack waits. "Talk to each other. Maybe you don't need to be here," says Jack, "I'll step out," and leaves the exam room.

He scrubs his hands vigorously at a nearby sink. Sylvia approaches.

"He hardly eats," she says, surprising Jack with her tone. Did she blame him for Brick's twenty-pound weight loss?

"There are special shakes you can buy. Doc Owens can help you with that."

Smacking his wet hands with a paper towel, Jack startles when Sylvia throws her hands into the air. "That's what Doc Owens did when I asked if the tumour had anything to do with his appetite. He changed the subject, zeroed in on his bowels. His bowels! You can set your watch to his colon. Now I ask you, and you toss me back to Doc Owens. What is this, a game of hot potato?"

"That's not fair," says Jack, about to say something rude he might regret later, when she kindly steps aside to allow a nurse to pass. She returns to the same spot, under the same fluorescent light, with the same incendiary glow to her cheeks. But now her rage has dissipated enough to allow Jack to see the desperation hiding underneath.

"What's going on with my husband?" asks Sylvia, shielding her eyes, as if wary of the information she desires.

"He fell. Doc wants me to check him out."

"That's not what I mean." She holds him in her grey, unblinking eyes.

"Brick is ill." Jack's mouth is dry. Was the truth his to spend? "He's very ill."

"You're wrong," says Sylvia.

"Inoperable lung cancer."

"No! A tumour, not cancer."

Jack's jaw falls slack. "Is that what Doc said, or what you heard?"

The corner of Sylvia's mouth twitches. "How do you know all this?"

"Doc told me."

"Why didn't he tell us? He said the X-ray showed walking pneumonia. The tumour was a 'by-the-way.' We shouldn't worry. He'd watch it. Watch it?"

Jack feels challenged to respond, to enlarge and justify her smouldering bitterness. He raises his eyebrows, invites her to continue, but it's clear his silence disappoints her. "You're twelve, you probably don't remember Dr. Riggins. When he died suddenly, we became Doc's hand-me-downs." She swallows hard. "The wrong doctor had the stroke."

"Doc Owens is a good man," says Jack.

"House scotch," she scoffs.

"What?" Jack asks, aware he's revealing that he's not much of a drinker, and this fact most likely will diminish him further in Sylvia's eyes.

Sylvia shakes her head. "Well, scotch. Cheap stuff, but it's better than nothing."

Jack bites his tongue, fights the urge to agree with her. Pain replaces words; pain he can tolerate. When the pain subsides, he excuses himself, steps outside into the ambulance bay. The sobering night breeze carries cigarette smoke and skunk from the municipal golf course across the street. Workers under kleig lights are digging up the tenth hole. Rumour is that the town is expanding Pickton Cemetery. Everyone talks about it and no one believes it. It's a curious counter to the common knowledge that the size of Doc Owen's practice has exceeded his diminishing abilities. Yet this fact is considered only obliquely, acknowledged with knowing expressions, never words. Jack imagines how "The Eternal Back Nine" would play out and visualizes tombstone foursomes of Doc's former patients packing the fairways.

JACK CALLS Doc's office, expecting the service operator who will page him. Even though it's 7 p.m. on a Friday, Doc is busy seeing patients, clearly annoyed that Brick remains in the "accident room."

"I accidentally told the wife Brick was dying," Jack says curtly.

"She knows about the tumour," says Doc. "The guy smokes like a chimney. They know. I didn't have to tell them."

Jack cups his hand over the phone so he isn't overheard. "The ER isn't a warm and fuzzy place to have a discussion about death."

"My office isn't warm and fuzzy, either." Doc Owens hisses into the phone. "Jesus, Jack. Why are you yanking my yingyang over this?"

He doesn't answer right away. Through the open door he catches Sylvia wringing a washcloth, pressing it against her husband's forehead, which Brick promptly removes. Candice squeezes her father's hand, rests her face against their messy ball of interlocking fingers. Brick turns to his daughter with a wry grin, appreciating her gesture and acknowledging its uselessness. Jack begins thinking: Did Doc Owens really decide to ignore the tumour and let Brick die? Many of Doc's patients are dying, or believe they're dying. This inexorable fate might discourage most physicians, those preoccupied with curing their patients; but for physicians in the sunset of their careers, or those who were never clinically strong, dying patients offer protection, a measure of comfort. Along with the body, sealed in the casket and lowered six feet into the soil, was everything the physician didn't know or do.

"In my day, we didn't treat people to death," Doc says, breaking Jack's silence. "When your time came, that was it."

"YOU SHOULD STAY in the hospital," Jack tells Brick. "At least overnight."

"What's wrong?" asks Sylvia.

"For observation. We'll watch him, maybe run some tests," says Jack.

Sylvia points to the scuffed linoleum floor. "He'll be here?"

"We'll get him a bed upstairs."

"Doc Owens will still be his doctor?"

"Of course."

"No. Not 'of course.'"

Brick closes his eyes. "It doesn't matter."

"We want a different doctor," Sylvia says.

"It doesn't matter," says Brick, forcefully now.

"Couldn't you be his doctor?" asks Candice, trying to mediate.

Jack steps back, thinks of Doc doing rounds on his patients every morning by 5:45, the dandruffed collar of his suit pulled askew across his stooped shoulders by the stethoscope stuffed into the jacket pocket. Jack lowers his voice. "Doc is a decent man."

"House scotch," Sylvia lashes out.

Brick's eyes spring open, round and glassy.

"What is it, Dad?" Candice asks, dabbing sweat from his cheeks.

"It's nothing," says Brick.

"It's not nothing," says Sylvia. "Why won't you talk to me?"

Jack feels her looking his way. To whom is she directing that question?

THREE HOURS LATER, still waiting in the ER for a hospital bed to come available, Brick begins breathing quickly, his skin paler than before. Jack marches his stethoscope up and down Brick's sweaty back. He hears sounds like crumpling sheets of paper. He's disturbed by this new finding. Sylvia and Candice step away, holding hands.

"How do you feel?" Jack asks.

Brick gives Jack a thumbs-up.

"Why is he breathing so hard?" asks Sylvia.

"Pulmonary edema." Jack twists the stethoscope into his white coat.

Candice nods. Sylvia doesn't pretend to understand. "Say again?"

"His lungs are filling with fluid."

"Why is this happening?" asks Sylvia.

Jack nervously leafs through the chart. "I can't say."

"Why not?"

"I mean I don't know," Jack bites back. "I can't piece this whole thing together." He pinches his tired eyes. How can he admit how lost his is? Then a nurse slips an EKG into his hands and Jack, embarrassed, breaks into an honest smile. The normal heart speaks in rhythmic, lean geometry. Brick's tracings reveal mountainous slopes, the silent screams of an acute heart attack.

"What's so funny?" asks Sylvia. Jack knows a smile at such a critical moment is inappropriate and deserves an apology, but he's truly elated and can't hide it. "Let's start over," Jack tells Brick, confident in the way people are when they have insider information. "Are you having chest pain?"

Brick responds with the slow, barely perceptible waggle of his index finger he uses to cut off drunks who believe they can hold one more. Jack leans into Brick's ear, holds his breath against the metallic odour wafting from Brick's cracked mouth. "You should've mentioned your chest," he whispers.

A grin splits Brick's tightly sealed lips. Rather than sly, he appears embarrassed at being found out, and grateful. The lung cancer is a red herring, Jack thinks to himself, the back pain a ruse, a strategy to get to the hospital. This way, Sylvia or Candice or the grandchildren wouldn't have the shock of discovering his body sprawled across the apartment floor or rocking stiffly in his chair. As Jack watches Brick's bluish lips purse around each shallow breath, he wonders how long Brick has been enduring the chest pain, concealing it from his family.

"Do something," Sylvia cries. "Don't just stand there."

Brick freezes Jack with his dark eyes, wet and threatening, in which Jack sees the steely soldier, the once-promising baseball player, the stern bartender—a man savvy to codes of discretion. The EKG traces an ominous and probably fatal path. The heart attack was kept hidden for a reason.

"Let's talk about DNR," says Jack, guessing that Doc Owens never raised it, and that Brick, by his actions, has declared his readiness to die.

He explains chest compressions, a breathing tube in the windpipe, other life-sustaining treatment. "Do you want me to do these things if your heart or your lungs stop working?"

Brick shrugs his shoulders. Jack feels a cold chill. If Brick is intent on dying, why did he respond with a shrug, as if being asked whether he wants bar nuts or pretzels with his pint?

"Stop talking," says Sylvia to Jack. "Help him."

"I need to know your wishes, or I'll assume you want everything done." Jack presses Brick, tilting his head, trying to communicate without betraying their secret. Finally, he asks, "What do you want me to do, Brick?"

Brick rests his head back against the gurney like a first-class passenger just before liftoff. He's breathing with his entire body, as if sucking air through a flat straw, but he appears strangely comfortable. Jack is stymied. How could he be so sure of himself moments before? The diagnosis wasn't the answer, only the spark that set fire to the question, "Did Brick really want to die?"

"You're watching my husband die," says Sylvia, neck vessels thickening. "How can you do that?" She squirms when Candice tries to embrace her. "Just like Owens."

That's when Jack finally gives in. He pushes his hands into latex gloves, glances at Sylvia, and responds with a litany of drug orders. The nurse flies about Brick's body, syringes loaded. Brick's heart will soon stop, regardless of what is done. But Jack exhales. A deep calm warms his veins. Each step is automatic, treating the disease easier than treating the person, but he can't shake the shame that what he's doing is wrong.

Jack believes in the beauty of a good death. In Brick's case, it means oxygen and morphine, calming Brick's air hunger until his breathing finds a tranquil groove. He waits beside Sylvia and Candice until the heartbeat in Brick's bulky chest goes silent.

Maybe Sylvia turns to Jack. "I knew something wasn't right," she says. "Thank you."

Perhaps Jack squeezes her hand.

But none of this happens. There are chest compressions and a breathing tube sitting between his vocal cords preventing any last hope of Brick saying goodbye.

The thrill of rescue pulls him along and Jack can't escape it, nor does he want to. Brick's blood pressure drops. Jack reacts. He knows exactly what is called for. The drugs keep coming. Doc's laxatives will be equally ineffective, but Sylvia doesn't know that, nor does Candice. Jack's lightheaded by this realization, nauseated too. He wonders if, and how, he'd ever be forgiven. Candice's wide face, thunderstruck, flushed with confidence and hope, answers him.

JACK CALLS Doc Owens. Wails echo in the background.

"What's that?" Jack asks, checking a wall clock—10:30 p.m.

"The Sirens of Mountain View."

"What?"

"Nursing home rounds."

"Brick Rolfson is dead," Jack says, deciding to come right out and tell him. "We coded him."

"It's for the best," Doc says dispassionately. "Brick was a fighter."

Jack chokes on that comment. "It's for the best?"

They share a tense silence. Jack needs to tell Doc exactly what happened, every detail. Brick didn't fight. Jack beat him up. He must confront Doc; never again will he dump a mess into his lap and expect him to clean it up. But it's late at night and Doc isn't home in bed. He's attending to his patients, probably doing the best job he can. And what would happen to these patients if Doc weren't there?

Jack quickly changes the subject. "Why call it Mountain View? This town is flat."

"Don't know, Jack. Why do they call it a nursing home? I've been rounding for an hour and haven't seen a single nurse."

Nervous silence fills the phone line. "Is Sylvie there?"

"She's with Brick. And her name is Sylvia."

"Say again?"

"Sylvia, not Sylvie."

"Right, right! Put her on, will you?" he asks.

Jack lowers the receiver and calls for her.

"Tell him to fuck off," she says.

Jack gets back on the phone. "She's pretty upset."

AFTERWARD, outside Brick's room while her daughter phones relatives, Sylvia surprises Jack by shaking his hand. "You did everything," she says, looking through him, as if he's obstructing her line of vision to the future. "Stop by Brick's Place, we'll take good care of you and your wife."

"Come by the bakery the next time you pick up your paper," Candice warmly offers.

"I'm sorry for your loss," Jack tells them, uneasy that they know of his wife and at least some of his routine. He avoids them as they wait for the funeral director to pick up the body. In his mind, he's giving them room to grieve. But he feels guilty, somehow at fault. Uncertainty shadows him as he dodges about the accident room seeing to other patients. It follows him home. He can't sleep. Perhaps that's really what the wine is for. He pads down the cool basement steps and stealthily feels his way without turning on the light.

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don’t climb any mountains

Alison C. Pryer

your glacial stare heaps contempt
on my trembling face.
fluorescent lights glare
off the white of gloss walls
and the white of your coat,
stripping me naked.
a wasteland of ice
stretches between us, widening
as your glittering steel pen
tap-tap-taps
a mound of paperwork.

i am bleeding, desperate,
as the child in my womb
drifts toward death.
my hope is slipping.
still, i cling on,
begging and bargaining
with god, with all gods,
with any god
who will listen.
but i know i cannot cheat them,
calling as i do only in times of need.

i want you
to place a hand of warmth

on my place of pain
where a contracting dream
lies buried, smothered
beneath my abdomen.
instead you dispense advice:
carry on as normal, just
don't climb any mountains,
you say,
and send me on my way.

we were one

we were one
once
you and i

the ancient celts
knew
a baby is created
whenever a woman swallows
a butterfly soul

you fluttered to my lips
kissing me with wing tips
anointing my hopes
the holy longing
of a woman for a child

i swallowed you
in the still point
of the love-night
while frogs serenaded us
from the forest

my nipples grew tender
as your body
mere curled tendrils
secretly
unfolded within me

for months
we were russian dolls
you and me
one hidden inside the other
a nested paradise of flesh and love

but a cold hand gripped
our womb
contracting
my heart
also

thick and dark
our lifeblood
flowed away
you were falling my butterfly
and i could not catch you

it's summer
again
i see other butterflies
at the forest's edge
and remember

we were one
once
you and i

Alison C. Pryer lives in Vancouver with her husband and two-year-old daughter. Her PhD research focused on the embodied self. Alison continues her explorations of this theme in her creative writing.

Death of a Surgeon

Carol Coleman Colapinto

As he lay dying, some of his things—a pair of shoes, his briefcase, his car keys, his car—
lived on, waiting for him.
Upstairs, his suits still hung in the bedroom closet, and all the clothes in his dresser drawers
were still there. But it was those things just inside the front door—and his car out there in the driveway—that waited. They were his everyday life.
They weren't momentous presences; they didn't jolt me as I walked by them; they were
part of the living world.

"Dr. Colapinto was operating on a hepatitis B carrier when it happened," said the Infection Control nurse. "The patient wasn't suffering from the actual disease."

We were in St. Michael's Hospital, standing just outside Vince's room in the Acute Care Unit.

Her voice was gentle. She said, "We also think you should know that it was not a drug abuser who infected him."

This last seemed beside the point to me; that the infection came from a solid citizen did not help. But she was kind, and I knew she said it to comfort me. Everyone was kind, I was surrounded by kindness, and it seemed to buoy me up when such a large part of me longed to collapse and be lying on the floor.

April 24, 1985, was the day Vince, my husband of thirty years, died—

a date I never forget, bad though I am at dates. My adored grandchildren's birthdates, for example, flee my mind and I have to consult calendars. April 16 also stays forever embedded; that was the day he went down to the hospital in an ambulance, supported by two paramedics, his legs crumpling beneath him on the stairs.

The date of the needle stick I'm unsure of, but I know it was mid-January. During surgery he pricked himself, re-gloved, and then did not bother to have a gamma globulin shot. His telling me this when he came home in the evening is the faintest of memories. I concentrate on it and it fades. Am I dreaming it? We seem to be standing in the kitchen, facing each other by the stove, with the dark window behind him as he tells me what happened. I think I remember feeling fright and indignation but not what either of us said—it all just slips away, as it did when I tried to call it up twenty years ago. But there was no panic. Vince's mentor, from his surgical training days, was Bruce Tovee, and Vince had told me that Dr. Tovee contracted hepatitis B during surgery back in the fifties, was sick for a few days, and then recovered completely. Also, in 1985 very few surgeons bothered to have the vaccine, though it was available. I'm afraid a certain lordliness in the attitudes of surgeons was as responsible as anything for this neglect of self. And although we knew something about AIDS at that time, blood-borne disease had not yet surged to the forefront of people's fears. I didn't go on worrying after the incident, and I'm sure he didn't either.

He was well for three productive months. He performed his surgeries, attended his clinics, saw his patients, worked on a paper, played his tennis. He was looking forward to doing a huge gardening job, and in April he had delivered to the house and stacked in the garage twelve enormous bags of peat moss to work into the flowerbeds. Just looking at them was exhausting. I see from an old calendar that we saw a play at the Royal Alex that April. I remember the evening, about two weeks before his symptoms began. We went with our friends Carol and Martin Barkin to dinner and then to the play. Vince was in good spirits. My silk scarf blew off in the windy parking lot, and we chased it through the slush.

On April 12 he turned fifty-seven. He was full of life, enthusiasm, and energy.

The next afternoon he developed a fever.

Vince was a busy surgeon, chief of the Department of Urology at St. Michael's Hospital. For our family, 1985 seemed to be a good year. I had recently done a refresher course in nursing and was working part time at Mount Sinai Hospital on the Psychiatric Unit. I had just turned fifty-one. Our four children were all getting along well in their lives. Ted, our eldest son, had finished medical school in 1982 and was training to be a surgeon. Robert, a York graduate, was working in reforestation and writing freelance articles, John had done arts at Queen's and now wrote for several magazines, and Ruthie was preparing to go to Trinity as a mature student in fine arts. Only twenty-one-year-old Ruthie was living at home.

The fever was not high, but as the day progressed he felt tired and out of sorts. Flu. He had played tennis that morning, as he usually did on Saturday, but without really feeling up to it.

Refusing to give in to illness was typical of him. I think it was on that day that I looked out the French windows in our living room and saw him sitting on the ha-ha, halfway down our garden.

I watched him for awhile because he looked pale, and tired and his position didn't look comfortable. He was very still and his face was turned to the afternoon sun. I remember this because the sight of him gave me a sad, uneasy feeling. A twinge. I didn't like to think of him viewing, as he surely must, those peat moss bags, nearby—that enormous project—and being discouraged.

On Sunday he felt worse and had a headache. He worked on his paper in his usual way: writing in a lined Hilroy exercise book, sitting on the low couch in the upstairs TV room, hunched forward over the coffee table, utterly focused—and with the TV on.

That evening the kids came up for dinner. Rob was off tree planting, but Ruthie, Ted and his girlfriend Michele, John and his girlfriend Donna were all there. I cooked an enormous rolled rib roast, and there was a meringue for dessert covered with lemon cream and fruit. I remember those menu details all too well because they haunted me later. Vince stayed upstairs so he wouldn't transmit his germs. Of course, everyone ran up to greet him and commiserate about his illness.

The children and I ate in the dining room, as usual. I know there must have been lots of laughing and talking. I remember him coming down to the kitchen at one point, with the mohair blanket around him like a shawl. I think I shooed him back upstairs.

After we'd finished, we were clearing up, and one of the kids brought Vince's plate down and set it on the counter. I can see so clearly and forever the untouched meat and congealed gravy. I don't remember if he touched the potato or whatever other vegetable there was. It was the uneaten roast beef that flashed me a warning that I didn't understand. He ate his dessert, and that thought is troubling too. The thought of him up there alone, eating every scrap of a rich dessert that must have made him queasy afterward.

On Monday he still felt bad. He was up and around, but was mostly sitting on the couch, working on that paper. I don't remember the details of the day. He asked me to go to Boots pharmacy to get him some headache pills, and I did.

He finally allowed me to call his doctor on Tuesday—either that or I simply did so—and I was told to bring him down to the office. I think this was early afternoon. Vince had been up but now was lying on our bed, fully clothed, and when I said we were going, he became strangely uncooperative, turned away from me, wouldn't get up.

Then I realized he couldn't get up. I could not get him down to the car. It was a feeling like no other. And Vince did not have flu.

When the ambulance arrived, the men came up to the bedroom and got him. I followed them as they half-carried him down the stairs. It was all unreal, and the numbness kept me calm.

I followed the ambulance down to St. Mike's in my car. There was no siren or speed. By the time I'd found parking and arrived, breathless, in the ER, he was on a bed with a curtain drawn around it, being examined. Our son, Ted, was already there. Everyone was puzzled. A doctor came out and asked me if Vince had been dealing with gardening chemicals.

Could that be it? They were trying to decide if he was jaundiced. I hadn't thought so, and neither had Ted. His face and hands were very hot when I kissed them.

His bladder bothered him and he couldn't void lying down. Ted helped him off the bed, holding him up as he tried to urinate but still couldn't.

Things are blurry for me here. Separate moments emerge from the morass of anxiety.

Vince is lying on what seems to be a low bed somewhere, and an old priest is giving him the last rites. I've never seen this before—the annointings, the cloths laid on feet and hands, all the elaborate, ancient ritual. I'm told it doesn't mean he's necessarily going to die, it's just in case. My Vince was not and never had been a Roman Catholic, but to be polite, he let it be assumed he was, because it was a Catholic hospital. Perhaps he doesn't realize what the priest is mumbling.

He is confused, an encephalopathy resulting from his kidney and liver failure.

At some point I go home to get his shaving things and pyjamas, as someone suggests, and I find his most presentable set—fine red-and-white checks—and begin ironing them but I can't seem to do it properly. Time seems to be all mixed up; I feel I've been ironing the pyjamas for ages. It's very like a dream.

As I am rushing through the hospital corridors, I meet Norm Struthers, Vince's colleague. He says, "Oh Carol, I'm so sorry." And I know by his face that Vince will die. His dark eyes are sad. Dark eyes show emotion more intensely than blue, and Norm's look clouded, dear man.

Vince was diagnosed with fulminant hepatitis B and admitted to the Acute Care Unit on April 17.

Our son Robert was contacted at his tree-planting site up north and he joined us. We were all there every day—Ted when he could get away from his radiology rotation at that same hospital.

We were given an empty room to sit in when we weren't at the bedside—the next one along the hall. I used to lie on the bed there and stare out the window at the brilliant blue sky above a red brick wall. Like a Technicolor sky, too blue to believe. The awful grief began to seep up through the anxiety. I knew he must die, and yet there was also hope. It was the saving of the children and me to be allowed that little space of hope, while deep down we prepared ourselves.

I think we owe our sanity to Mark Goldstein, the nephrologist. He somehow joined with us seamlessly in that room, while going on with his work. He worked doggedly, heroically, and we always knew he was horrified along with us, that he minded terribly. We knew that if Vince could be saved, Mark Goldstein would do it, and this was immensely comforting. In a white gown and boots, he dialyzed Vince, started IV lines, injected medications. Oh, those huge bottles of water he lugged and poured. Sometimes when I arrived in the morning he would tell me there was a tiny improvement in certain blood levels. "We're talking about tiny increments," he'd say.

He was truthful always, but he never said that all hope was gone, and he worked like a Trojan. Sitting here at my computer, thinking of that marvellous doctor brings tears. Here was goodness and kindness, intelligence and forthrightness. To this day it's overwhelming. I have never seen him since that terrible time, and I will never forget him.

There were telephone consultations with at least one medical centre in the States. I associate that fact with Dr. Bernard Langer's visit. He came in one day with a small entourage. He was the tall, intimidating head of the Department of Surgery at University of Toronto. He sat with me a while, but I remember nothing, except that I was uncomfortable and couldn't think of anything to say.

Vince was still conscious but he seldom spoke, and what he said didn't always make sense. I think it was on Sunday night that the end began.

When I got to the hospital Monday morning, everything had changed. He was unconscious and hooked up to loud breathing machines. His eyes had closed forever. The whole room was a new nightmare. In the early hours he had gone into status epilepticus. I remember Ted arriving and walking into the room. Something he was carrying—I can't remember what it was—he didn't just drop, but cast forcefully to the floor in his anguish.

Vince's body never dwindled, never lost muscle tone. There wasn't time for that, so he stayed looking himself, lying there in that welter of tubing. His chest and arms never changed. And because he received the most exquisite nursing care, he and his sheets were always fresh and clean, and every morning his beautiful face was meticulously shaved.

We are outside of time. Memories float up but have no set place.

I keep talking to him, as he lies unconscious, just in case he somehow can hear me. I find a place on his arm that has no intravenous line and lay my hands there. The machine is so loud I have to raise my voice when I badly want to whisper to him.

It is a warm April—a heat wave, in fact. The sun shines every day.

The window in his hospital room is open a few inches, and a warm breeze comes in, bringing back all the other summers in a rush. Somewhere to the east of the hospital there must be a tennis court because I can hear the rhythmic thock of tennis balls in play. Almost unbearable because our summers, especially his and the children's, have been full of tennis. But maybe, if he hears it, lying in his separate world, the sound evokes pleasure for him.

His separate world: each evening I leave him in it and go home. I park behind his car, which is in the driveway, blocking access to the garage, as always. I go in the front door and past those everyday things of his that lie on the vestibule floor and the hall table, so naturally, so blandly: his brown loafers with the leather stretched in the bunion area, his tan briefcase with journals sticking up from the side pocket, his keys there on the hall table.

Robert sleeps at the house every night. The desperate, quiet distress on his face is one of the worst things. He is the one who looks most like his father. I see him asleep in the mornings and can't bear to think of him waking to all the horror, yet again.

John, my youngest son, is growing a beard. It is to stay for a year. He has a way of placing his large hand flat on the wall of our room next door to Vince, just to keep the connection going between himself and his father. This breaks my heart.

Ruthie is a different person now. She says very little and seems delicate, transparent, withdrawn. We are attuned to each other. We hold each other a lot—often wordlessly. I manage to persuade her not to come down to the hospital every day.

On weekdays, the boys go to him in the evenings and sit talking together beside him or in the room next door. Sitting right there by the bedside for long periods is too overwhelming. We all find this.

One of my dearest friends is married to an Anglican minister, Tom Little. One day he drops by unexpectedly, without Marg, his wife, and as I approach Vince's room—possibly after eating lunch—he comes out of it in his black suit and clerical collar and says, "I've just been holding Vince up to God." I don't quite know what this means, but the mental image it calls up suits my desperate state and pleases me.

Vince was the first-born of three sons of Italian immigrants (who predeceased him by a couple of years). He was worshipped in his home, and his word was law from quite a young age. I think this all-out adoration steadied him and sheltered his ego during the war years when Italy was the enemy and he was hearing words like *wop* and *dago* quite regularly. He told me once that some respected newsman ended his daily broadcasts with the words, "Never let a dago by." So there he was, reading Arthur Ransome (*Swallows and Amazons*) and identifying with those little English sailors, while being told he and his family were different, disgusting, and bad. But he worked hard at school, was an excellent student and was so loved by his parents that he never lost track of his true self, of the fact he was a good boy as well as smart. Of course, in all his life he never completely lost that "outsider" feeling, and those early hurts gave him an understanding of the feelings of others and sensitivity to their pain. Doctoring was the perfect profession for him.

He was a calm person with enormous natural dignity, and he was brilliant. He was the man to have around during any catastrophe. When Ruthie, at about four years old, lost the tip of her finger in a door-slamming incident with a brother, Vince walked in on the scene when he arrived home for dinner—to wild-eyed me coming down the stairs holding a shrieking, bleeding Ruthie. He assessed the wound in an instant, strode to the door in question, and actually found the fingertip pasted to the frame by blood and tissue. As I held her, he quickly put the tip back on—I don't know who ran for the tape and gauze—and in minutes had her all in one piece. I used to wonder how anyone could feel safe unless married to a doctor. But no other doctor was Vince.

Now it has all narrowed down to this high bed, these white sheets, this prostrate form, these machines. Nothing on earth can help him now. We are approaching the very end, and on Tuesday at some point—I think toward the evening—he is moved into the Intensive Care Unit.

The next morning, Ted is called at his apartment in the early afternoon by one of the doctors. He has unplugged his phone, very briefly, and is lying on the floor, having given way temporarily to despair, as he tells me later. (And here I must interject that the "anger" stage of grief—for me—was and is about the pain my four children suffered. We know what we can bear because we're bearing it. But to watch innocent, beloved others struggle bravely is profoundly worse.) Ted soon returns their call and is asked to come to the hospital. They want to discuss taking Vince off life supports. When Ted arrives, he sees the blood surging up in Vince's endotracheal tube with each breath and he immediately says it must stop now.

I leave the room and return to him when the tubes are gone. He has settled back into a more peaceful state. I can stand close to his face now that the machine isn't there, and I can see, in the blessed silence, his long lashes, childlike on his cheek.

At 3:30 in the afternoon I'm in our special waiting room when I'm told he has had a vast internal hemorrhage and has gone. In the hospital corridor there is a grey fuzziness to everything as if it's early evening and it isn't. There is a huge boulder of ancient stone lodged in my chest. I must move carefully.

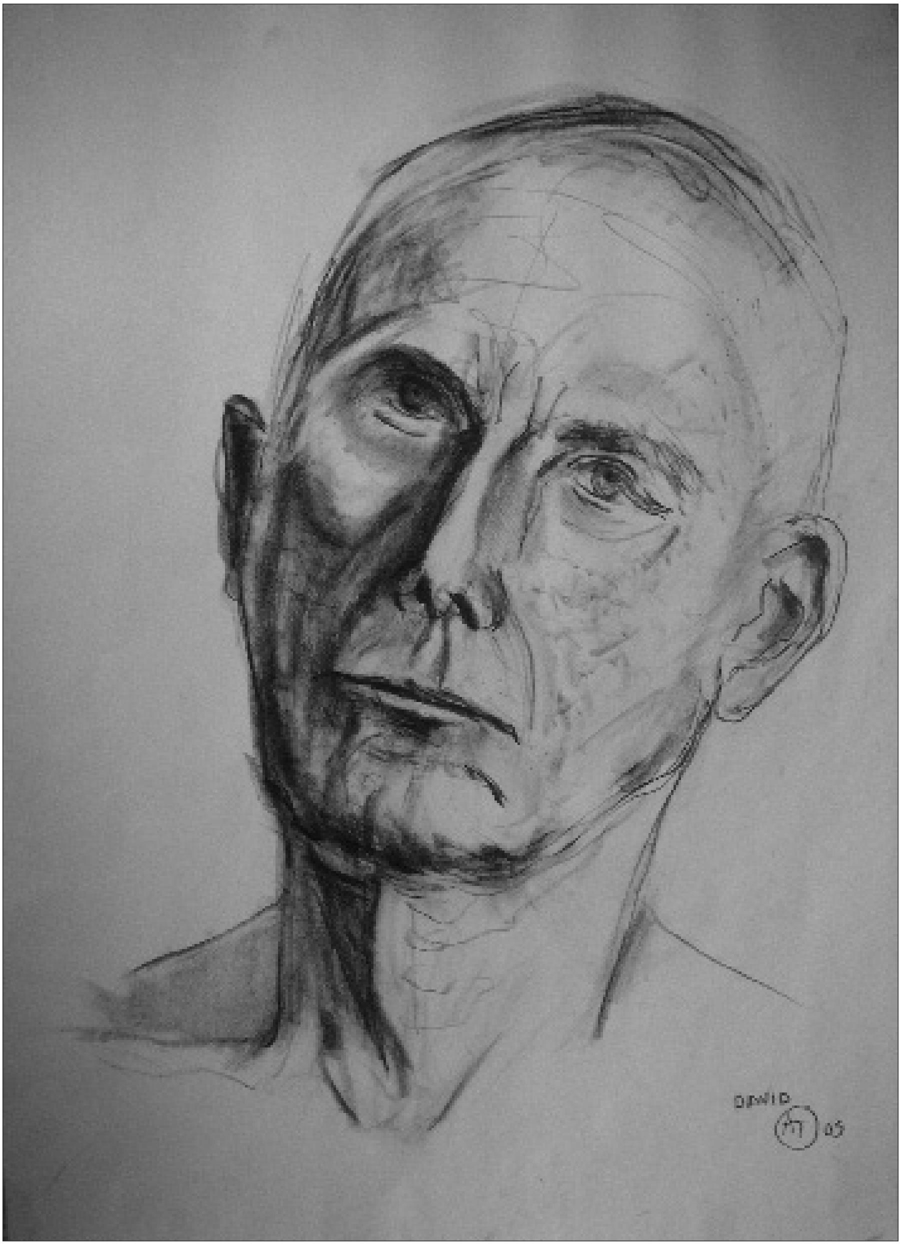
Someone suggests we may want to view his body, and we refuse. We will never see him dead. That would be an unbearable sight to haunt us forever and we will not risk it.

ALL HIS EVERYDAY THINGS stopped waiting and died. When I looked one day, the leather shoes and briefcase were filmed with dust. They had no meaning and had ceased to be.

Many years later I had a stone cut for Vince in the necropolis near my new house. Vince's remains are up in the Mount Pleasant Cemetery, but I wanted another tribute to him nearby. It says his name and then the last stanza of a poem I chose by Robert Frost called "The Soldier":

> But this we know, the obstacle that checked
> And tripped the body, shot the spirit on
> Further than target ever showed or shone.

Carol Coleman Colapinto lives in downtown Toronto. She is a writer whose work has appeared in *Room of One's Own*.



Portrait of David (2004). Charcoal, 40 x 60 cm.

Alex Tarnopolsky is a psychoanalyst in Toronto, head of the Psychological Trauma Programs in Mount Sinai Hospital and Whitby Mental Health Centre. He has been drawing and painting all his life.

Comfort

Shirley Adelman

One collection, a notable review,
poetry and prose softbound, lavender-
covered in paper smooth as tapioca.
A comfort to my hands, braceleted
in hospital tags.

No sound perfect as Peace,
Hallelujah, Amen soothes pain,
like the touch of a page.
Equal at last.

A teenager, moon faced from steroids,
a halo of wispy hair round her baseball cap.

A shrunken woman alone, taking half steps
with a walker.

A son lifts his mother to a wheelchair.
"A piece a crap," he says as it rolls away.
"Donated." "See you in three months,"
she announces, smiling, pleased to have
a date with the future.

The regulars are at home, snoozing between
rounds, complaining about sandwiches too
dry to eat, waiting it out for packets of mayo.

Here in the Infusion room we are equal, at last.
All poor, robbed of health, pale, wanting kindness,
a hot cup of sweet coffee, carefully placed
in our cold hands, something to hold onto.

Some will recover and forget to remember
how the poor live: day to day.

Shirley Adelman's work has been internationally published, most recently in *Healing Muse, Blue Collar Review, Kaleidoscope: Selected Works of Poetry & Fiction,* and *Jewish Currents.* She is a college teacher and the mother of two adult children.

Is There a Medical Doctor on the Plane?

David S. Goldbloom

"Is there a medical doctor on the plane?" It is the overhead announcement that many physicians dread, fearing everything from a problem outside their zone of competency to a multimillion-dollar medico-legal risk.

I heard it recently. I had just completed a course on evidence-based mental health. When the call for a physician interrupted the feature film audio track, I looked around the packed airplane for a wise Marcus Welby type to rise and identify himself. To my amazement, everyone stayed seated, noses buried in the compelling plastic folders that explain the safety features of the aircraft.

Gingerly, I approached the flight attendant and explained that I was indeed a physician, adding that although I was a psychiatrist, I had recertified in CPR and automated external defibrillation a month earlier. Even more recently, of course, I could provide an emergency talk on effect sizes and funnel plots—but I withheld this valuable addendum from the increasingly suspicious flight attendant. She asked if I had proof on me of my medical status. I was tempted to recite the rather filthy mnemonic I had learned in medical school to identify the bones of the wrist (I had long forgotten what the actual names of the bones were, but the stereotyped roles of Sally and Tom in the mnemonic had stayed with me). I didn't have a wallet-sized copy of my diploma on me, but I suggested she could radio ahead to the hospital where I worked. She demurred at this point and asked me to see the woman in seat 21F (for confidentiality reasons, this is not her actual seat number), who was in some distress.

My first and only airborne patient was a fifty-nine-year-old East Indian woman on a long flight that had originated in New Delhi (again, for confidentiality reasons, it was actually another city in India). I introduced myself as a physician and asked her what the problem was. She replied, "I'm feeling uneasy, Doctor." At 29,000 feet, that made two of us. Seeking elaboration of this chief complaint, I probed for details. She could provide none beyond a general sense of unease.

Clearly this called for the review of systems that I had mastered as a medical student. Traversing the repertoire of cardiac, respiratory, gastrointestinal, and neurological symptoms bore no fruit. And she still felt uneasy.

Inquiring about medical history, I learned that she was Type 2 diabetic, hypertensive, and had had a myocardial infarction five years earlier—"in the Punjab!" her husband added vociferously. I commiserated, sharing my knowledge that infarcts in the anterior Punjab were among the most serious.

I asked if she was on any medications. She proffered a small crinkled piece of tinfoil, which I unfolded delicately, exposing five single pills, each of a different colour and shape. I gazed at them knowingly, offering a comforting "uh-huh" as I speculated aimlessly about their possible names and roles. One was still in a torn blister pack with the fragmentary message " . . . olol" still visible. I pointed to it and suggested this was for her blood pressure. She and her husband responded with relief at my acumen.

Since the flight attendant had handed me a large medical kit, I rummaged through it to see if there were any instruments I recognized. I took her pulse (normal) and her blood pressure (also normal). I offered to listen to her heart, and she accepted gladly. I threaded the stethoscope down the front of her sari under the watchful eye of her husband (there was nowhere else on the plane to conduct this detailed physical examination). Hearing the familiar "lub-dup" sounds and no extraneous noises (0S3, 0S4, 0murmurs, as we used to write), I told her that her heart sounded very strong. She expressed relief. At this juncture, I was largely tapped out of diagnostic options. I asked her when she had last eaten. It was seven hours earlier. Summoning up my best television doctor voice, I barked out a "stat orange juice!" order to the flight attendant.

She drank the orange juice happily, and before I returned to my seat I pointed out its location to her, saying I would be back in ten seconds if she had a problem. She and her husband thanked me, and I returned to the spectacular first-run film that Air Canada provided. The flight attendant brought me some forms to complete that resembled income tax returns, only longer. She also thanked me for my intervention. I asked her to check on the woman in ten minutes and let me know how she was doing.

Ten minutes later, the flight attendant returned to advise me that the woman and her husband were both sound asleep. Quietly, I asked if she could tell me whether she had noticed if the woman's chest was moving up and down. It had occurred to me that I might have had the final medical visit to this woman. The flight attendant responded immediately that she and her colleagues are trained to check for chest wall excursions in sleeping passengers. I was, for the moment, reassured. I felt better when I watched the woman walk off the plane.

I will never know what was the cause of her distress. Mercifully, it was not something that acutely (i.e., prior to exiting the baggage carousel) threatened her health that I could discern. The laying on of hands and the provision of reassurance (not to mention orange juice) are the non-specific residua of bedside teaching in medicine that may work at a number of altitudes.

David S. Goldbloom, MD, FRCPC, is senior medical advisor, Education and Public Affairs, at the Centre for Addiction and Mental Health, as well as professor of psychiatry at the University of Toronto.

vasectomy

Peter Roberts

all the talking is over.
so's the waiting. i
arrive at 6:30 am, in
calm darkness, last instalment
of the night. the doctor appears,
at almost 8, ready to begin.
the sun is now up, shining through
the slatted window, filling the room
with dazzling, sharp light,
brighter even, overall, than
the surgical lights. i have been
shaved, my motives, feelings, decisions
laid bare. although the anesthetic
blocks immediate pain, it doesn't obscure
what is now taking place.
no knives, no scalpels, only
scissors—snip, snip—
cut an x in my scrotum, reveal all
that is to be finally severed.
there is no pain, but some pulling
& tugging, & much
apprehension about
this invasion
of my body, of my life.
apprehension, too, & some pain, about
starting a new stage in my life,
in front of, even with the aid of,
these strangers, supportive
as they are, as they have been.

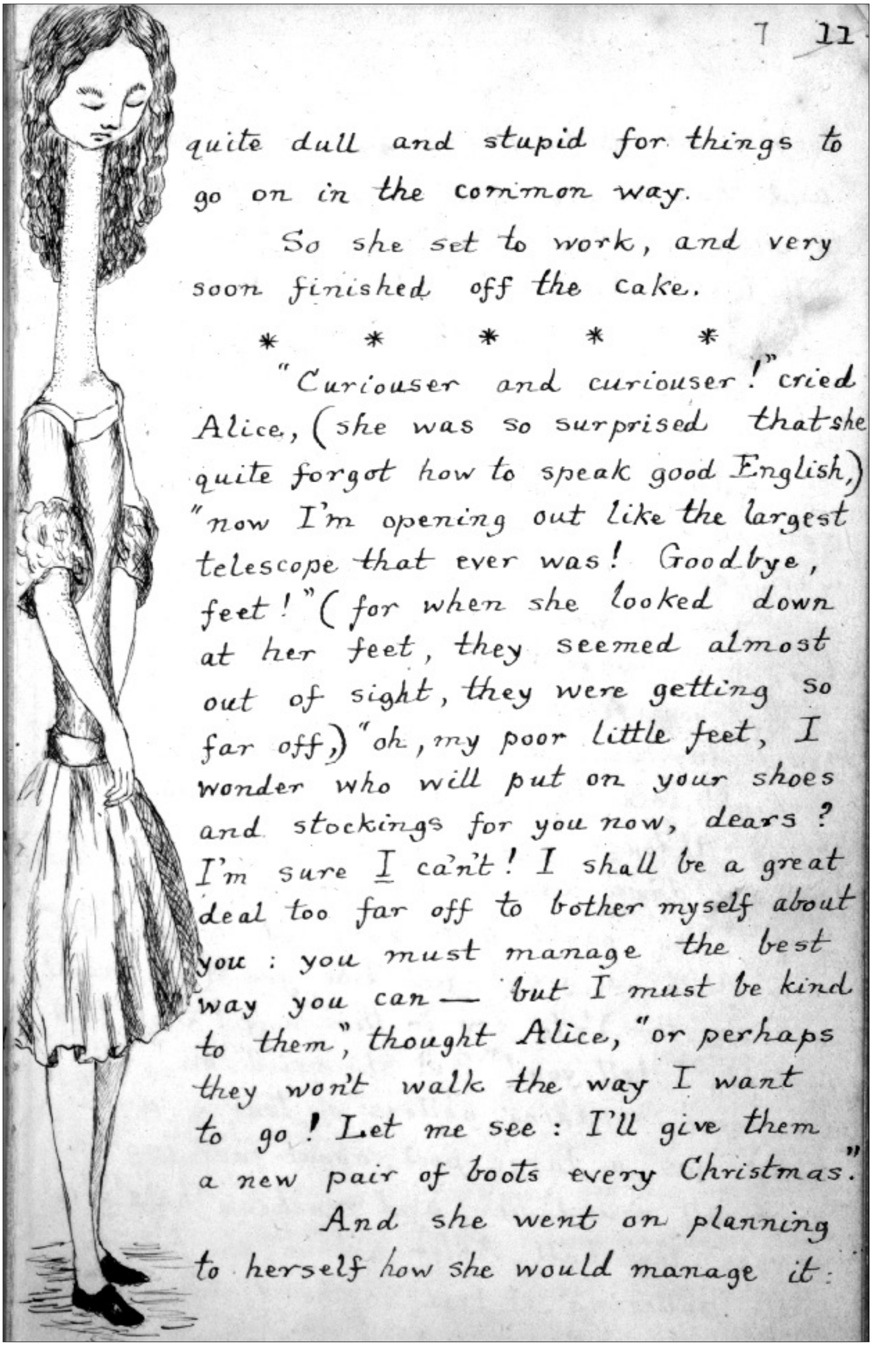
—snip, snip—scissors, again,
cut the vas deferens, & i know
what has been removed. the loose ends
are cauterized, seared, sealed.
never again will i hold a baby that's my own;
never will i hold a daughter. i'm too old.
i know i'm too old to begin it all again.
the wound is small, & soon the surgeon
has laid the 4 corners back
together, held tight with glue.
the steps are repeated
for the other side, then
it's over. there's not much
blood. a faint odour—burnt flesh—
lingers in the sun
-saturated air, almost
visible as smoke. I
have come through this well. a short stay
in recovery, & i'm ready to go home.
even after the local anesthetic
has worn off, there is little pain.
the wounds ooze a little, but only
for a few days. the bruising
lasts longer, but soon enough
fades to nothing, & my life
continues, almost
the same as before.

Peter Roberts grew up near Pittsburgh and earned a BS at the University of Pittsburgh. Over the past thirty years or so, his poems and stories have appeared in numerous literary magazines.

Alice's Adventures in Wonderland: A Metaphor for Human Development

Chetana Kulkarni

The highly irregular and often unpredictable process of growing up has been studied in many fields. Yet for someone going through it, this research often means very little. Information about maturation is often inaccessible or inaccurately expressed to those to whom it would most readily apply. This lack of information was particularly prevalent in the Victorian age when many children were not educated about the changes that would naturally occur as they progressed from childhood to adulthood. In fact, as recently as the 1950s, up to half young girls were given no warning about sexuality or menarche. Today, no more than 15 per cent of girls are in this position. It would have been particularly relevant in the Victorian age to provide children with some method of learning about puberty. Lewis Carroll's *Alice's Adventures in Wonderland* provides a distorted, fantasy-like vision of the process of growing up. Yet, disturbingly, it seems to be one of the more accurate sources of information available to girls of that time. Although we cannot say whether Carroll intended his story to be taken at anything more than face value, it can be said that *Alice's Adventures in Wonderland* is a consistent prediction of maturation that encompasses biological and psychological factors that are inherent in this process. In a sense, it is a warning to the "real" Alice, Alice Liddell, and others like her, of what to



quite dull and stupid for things to go on in the common way.

So she set to work, and very soon finished off the cake.

* * * * *

"Curiouser and curiouser!" cried Alice, (she was so surprised that she quite forgot how to speak good English,) "now I'm opening out like the largest telescope that ever was! Goodbye, feet!" (for when she looked down at her feet, they seemed almost out of sight, they were getting so far off,) "oh, my poor little feet, I wonder who will put on your shoes and stockings for you now, dears? I'm sure *I* can't! I shall be a great deal too far off to bother myself about you: you must manage the best way you can — but I must be kind to them," thought Alice, "or perhaps they won't walk the way I want to go! Let me see: I'll give them a new pair of boots every Christmas."

And she went on planning to herself how she would manage it:

Alice eats cake and grows tall. By permission of the British Library.

expect in the near future. His interpretation of the maturational process shows remarkable insight, particularly in light of the fact that the society of the day was not generally well informed about human development.

For girls in the 1990s, the height spurt and menarche begin, on average, at ages ten and a half and thirteen respectively, with normal variation ranging from eight to thirteen for height spurt, and ten and a half to fifteen and a half for menarche. This is a decrease from the average age of menarche of fifteen in southern England in the 1860s, when *Alice's Adventures in Wonderland* was written. This secular trend in female maturation has been observed for over a hundred years. Although the average ages of maturational events has decreased in females, the range of ages has remained consistent. It can be extrapolated that the age range for menarche in the 1860s was twelve and a half to seventeen and a half, with the beginning of the height spurt occurring at roughly ages ten to fifteen. Oddly enough, Alice is seven years old in the story, which indicates that she still has some time before puberty. It is possible that Alice is an extremely early developer, but it is more likely that she has learned about growing up from her two older sisters, perhaps through observation. Her adventures in Wonderland are therefore a vision of her future, based on her limited knowledge. Wonderland is not just a child's fantasyland; rather, it is a source of information that is provided by Carroll.

One of the first indicators of the onset of puberty in females is the beginning of the height spurt. Throughout life, human growth follows cephalocaudal and proximodistal trends. These trends are, however, reversed at puberty. In addition to the reversal, growth is often uneven, resulting in the fact that "many young teenagers appear gawky and out of proportion—long legged with giant feet and hands" (Berk, 170).

Alice experiences the phenomenon of uneven growth in Wonderland, albeit in a definite Wonderland fashion that is mixed up and clearly distinguishable from reality. Alice changes size eleven times during her adventures, with a few particular occasions when her growth is obviously disproportionate. One of these instances occurs at the beginning of her adventures: "When she looked down at her feet, they seemed to be almost out of sight, they were getting so far off" (26). Although this growth pattern is contrary to what she will experience in reality, it is consistent with the reality of Wonderland—close to what we would expect, but distorted enough to be passable as a fantasy. It also serves to prepare her for the time when she will have her "real" growth spurt, and the fact that parts of her body will not be in proper proportion. Another illustration of Alice's disproportionate growth is her first attempt to control her growth using the magical mushroom. Her neck grows to "an immense length of neck, which seemed to rise like a stalk out of a sea of green leaves that lay far below her" (55). The fact that she is called a serpent, an animal that sheds its skin to become an adult, further emphasizes the idea of maturation in this example. This time, however, her growth occurs just after she confesses that she is not "particular as to size" (53), but she "doesn't like changing so often" (53), indicating that although the process of growing up intrigues Alice, she wonders if and when it will ever be completed.

Increased hunger is also an aspect of adolescence, which is of course related directly to physical growth. The rapid growth of puberty invariably leads to an increase in food consumption. Food or drink cause the majority of Alice's changes in height, with the exception of one caused by the white rabbit's fan. These changes are consistent with increased appetite that occurs during puberty and also with the fact that children are "very hungry on the day before the [growth] spurt" (Berk, 169). In Wonderland, however, satiety of this hunger yields an immediate change in size, either an increase or a decrease, while in reality growth occurs in a stepwise fashion.

Research findings have shown that "girls' feelings about menarche depend on prior knowledge" (Berk, 181). Menarche can be shocking and disturbing to girls who have no advance information about sexuality. Those who are informed usually react with excitement and pleasure, which is mixed with some fear due to the sudden onset of menarche. Girls who are informed often eagerly await this transitional period of their lives. Alice falls prey to this anticipation, as she spends over half of the story attempting to pass through the "little door about fifteen inches high" into "the loveliest garden you ever saw" (22). In fact, she "longed to get out of that dark hall, and wander among those beds of bright flowers and those cool fountains" (22–23). When she finally does find herself this garden of adulthood, the first thing she finds is a "large rose-tree" (77). What is special about this rose-tree is that "the roses growing on it were white, but there were three gardeners at it, busily painting them red" (77). As she finally moves into the realm of adulthood, the white roses of her innocent childhood are being transformed into the red roses that signify menarche. As she embarks into adulthood, the three gardeners symbolize the three stages in the female life cycle—prepubertal, reproductive, and post-menopausal. Carroll is accurate in leaving menarche until midway through Alice's adventure through puberty, as "menarche actually occurs fairly late in the sequence of pubertal events" (Berk, 178).

Western cultures have often been criticized for their lack of rite of passage to celebrate movement from childhood to adulthood. In many tribal societies puberty is commemorated with a ceremony that "marks an important change in privilege and responsibility" (Berk, 182). In most industrialized countries, children are granted a series of privileges that give them partial adult status, resulting in the peculiarity that they are treated as adults in some situations and as children in others. This same condition held true for upper-class Victorian England. The "absence of a widely accepted marker of physical and social maturity makes the process of becoming an adult especially confusing" (Berk, 182). This Western oddity explains why Alice changes size many times during her adventures. She does not simply grow physically taller. She experiences the confusion of being too big in some situations, such as too big to fit through the door and so big that she fills the white rabbit's house, and too small in other situations, such as shrinking so small that she cannot reach the key to open the door. Her adventures serve as her rite of passage into adulthood by providing her with markers of social and physical maturity, so she will not be confused when puberty actually begins.

Did Carroll intend *Alice's Adventures in Wonderland* to be a rite of passage or a prophecy for Alice and other young girls? It was certainly meant as a method of entertainment, as a statement about the world, but also as a method of education. Consequently, under its ludic exterior, the story has some very important instructive elements. It educates the reader about Victorian society, but also about what to expect in the process of growing up. This was especially important in an age when most children were not informed about what to expect as they began to mature. Indeed, the story is a prophecy surrounding puberty to help Alice Liddell understand the process and to help her cope with the changes that will occur. Although many of the jokes and references are not understood today, the relevance of the information about puberty still remains. Carroll's method of telling girls what they could expect in their future was relevant when it was written and is still relevant today, particularly since, nowadays many of the foretold events occur at an age closer to Alice's age in the story. It is clear that over a hundred years later, Carroll's book is an accurate tool that can be used by children to understand a process that they must go through, but over which they have no control. As Alice says to the Dormouse, "I can't help it . . . I'm growing" (106).

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Dr. Kulkarni attended University of Waterloo, where this essay was written for a children's literature course. She graduated from McMaster University School of Medicine and now specializes in child and adolescent psychiatry at University of Toronto.

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Aphorism

Jim Huntley

The first part of the first aphorism of Hippocrates appears on the wall of the Medical School, Teviot Place, Edinburgh. Translated in full, the aphorism reads, "Life is short, science is long; opportunity is elusive, experiment is dangerous, judgement is difficult. It is not enough for the physician to do what is necessary, but the patient and the attendants must do their part as well, and circumstances must be favourable."[1]

Alternative translations replace the word *science* with *the art*[2] or *the craft.*[3] Would Hippocrates have concerned himself with such distinctions?

Notes

1. Hippocrates, "Aphorisms," *Hippocratic Writings*, trans. J. Chadwick and W. N. Mann (London: Penguin Classics, 1983).
2. *Concise Oxford Dictionary of Quotations,* ed. A. Partington, 3rd. ed. (Oxford: Oxford University Press, 1997).
3. *Oxford Dictionary of Quotations,* 3rd ed. (Oxford: Oxford University Press, 1983).

Jim Huntley is a clinical lecturer in orthopedics and trauma. He works in Edinburgh, but lives away from the city, by the sea.


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